

AMERICAN MEDICAL TIMES

Being a Weekly Series of the New York Journal of Medicine.

No. XXIII. { NEW SERIES. VOL. III. NEW YORK : SATURDAY, DECEMBER 7, 1861. { *Mail Subscribers, \$5 per Ann.*
City and Canadian, \$3 50 "
Single Numbers, 10 cents.

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Original Lectures.

LECTURES ON AUSCULTATION, PERCUSSION, ETC.

DELIVERED AT THE
BELLEVUE HOSPITAL MEDICAL COLLEGE, DURING THE
PRELIMINARY TERM.

SESSION OF 1861-62.

BY AUSTIN FLINT, M.D.,

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LECTURE VII., PART II.

Definition of Râles and their Classification.—Coarse and Fine Moist Bronchial or Mucous Râles.—Sub-Crepitant Râles.—Sonorous and Sibilant Râles.—Gurgling.—Crepitant Rôle, its Distinctive Characters, Diagnostic Significance, and the Mechanism of its Production.

THE auscultatory signs of disease which I have thus far considered, are all morbid modifications of the normal vesicular murmur. I come now to a group of signs which are distinguished from those already considered, in this: they are not the sounds of health modified, but they are new or adventitious sounds; they are altogether the products of disease, and have no types anywhere in the healthy chest. What generic name shall we apply to these sounds? Laennec called them *râles*. English writers have preferred to use the Latin terms *rhonchus*, *rhonchi*. The latter terms are objectionable on account of their roughness. If you were to tell a patient that he had a "rönchus" in his chest, he would imagine that it was something formidable, while, if you said that he had a "rôle" he would not be alarmed. The French term is more euphonie, and I think we should continue to use it.

There is generally a very mistaken notion in the minds of those who have given little or no attention to physical exploration as regards the importance of the râles. They are apt to suppose that knowledge and skill in auscultation relate chiefly to these adventitious sounds. This is far from being true. The abnormal modifications of the respiratory sounds which have been considered, are vastly more important than the râles. The greater part of the latter are comparatively unimportant. They often annoy us, instead of affording valuable information, by obscuring or drowning more important signs pertaining to the respiration.

Another mistaken notion is, that the râles constitute an intricate portion of auscultation. This notion has arisen from the fact, that some writers have made numerous minute and useless distinctions. Were all the varieties of adventitious sounds to be described as separate signs, the subject would indeed be complicated, for the number of râles might in this way be multiplied indefinitely. It answers all practical purposes to arrange the different sounds into a few classes, considering each class as constituting a single sign; and the classification is so simple that I hope to be able in a few words to make the subject intelligible.

The râles, in the first place, are divided into those which are dry and those which are moist. The moist râles convey to the mind the impression of moisture or of the presence of liquid. They are for the most part produced by air bubbling through liquid, and hence they are sometimes called bubbling sounds. The dry râles, on the other hand, do not convey any impression of moisture: these are sometimes called the vibrating râles.

Next, they are divided according to the particular situation in which they are produced. Both dry and moist râles may be produced within the bronchial tubes, and they differ accordingly, as they are produced in the larger sized or the smaller tubes. A single moist rôle is produced within cavities more or less filled with liquid; and a single dry rôle is produced within the air vesicles.

AM. MED. TIMES, VOL. III., NO. 23.

Now, what are the moist bronchial râles? They are three in number, viz. coarse, fine, and subcrepitant râles. If you blow into a large sized tube containing liquid, you produce a character of sound due to the large size of the bubbles, which may be distinguished as coarse. The bubbling sound in the larger sized bronchial tubes has this character. Coarse moist bronchial râles are, therefore, situated in the larger sized bronchial tubes. They denote the presence of liquid in these tubes. The liquid is generally mucus, and, hence, all the moist bronchial râles are frequently called mucous râles; but they may be due to other kinds of liquid, viz. serum, pus, and blood. Coarse, moist, or mucous râles may, therefore, occur in connexion with any disease in which liquid accumulates in the large tubes. This rôle is represented on an exaggerated scale when liquid accumulates within the trachea, as it often does in the last moments of life, the sounds being loud enough to be heard at a distance: these are tracheal râles or the death rattle.

When the bubbling sounds come from smaller tubes, they are said to be fine. The impression conveyed is that of small bubbles. The fine râles signify the presence of liquid—mucus, serum, pus, or blood—situated within the smaller tubes. They occur in certain cases of bronchitis in the second stage, i.e. after mucus is secreted in abundance, and, in this affection, they are likely to be present on both sides of the chest, for bronchitis is one of the symmetrical diseases, affecting both sides about equally, if it be primary, and not a complication of some other pulmonary affection. If the mucous râles, whether coarse or fine, are confined to a circumscribed space at the summit of the chest, they denote that the bronchitis is secondary, and in all probability it is a complication of tuberculosis; hence, thus limited, these râles belong among a group of signs which denote, inferentially, the existence of tubercle. But they are incident also to pneumonia, to abscesses evacuating through the lung, and to hemorrhage.

The coarse and fine râles, especially as connected with bronchitis, are very variable, being now present and now absent, now at this point and now at another point; which is intelligible enough when we consider that the mucus is not stationary, but shifting its situation as it passes onward to be expectorated. The subcrepitant rôle is neither more nor less than a fine mucous or moist bronchial rôle. The reason for calling it by this name will appear presently; the rôle comes from the minute bronchial tubes. It is a valuable sign, as denoting that rare and dangerous variety of bronchitis called capillary bronchitis. When it exists on both sides of the chest, and is more or less diffused over the chest, it generally denotes capillary bronchitis. With regard to the three varieties of moist râles, this is to be borne in mind: they are heard both in inspiration and expiration, in either act singly, or in both acts.

The dry bronchial râles consist of two varieties only, viz. the sonorous and the sibilant. The distinction is based on the pitch of the sound. If the sound be low in pitch it is a sonorous rôle; if high in pitch, it is a sibilant rôle, or, as it is sometimes called, a whistling rôle; the varieties of each, as regards the characters of the sound, aside from the pitch, are numerous, but they are of no practical consequence. Both kinds are often musical, especially the sonorous kind, the sound resembling the note of a bass-viol or bassoon, the cooing of a pigeon, etc. Both râles may accompany the inspiration or the expiration, either alone, or together. The sonorous, however, is often heard with expiration, and the sibilant with inspiration; both may be heard at the same time, the sibilant with inspiration, and the sonorous with expiration.

The dry râles signify contraction of the calibre of the bronchial tubes at certain points, generally in consequence of the adhesion of tenacious mucus too dense and viscid to produce bubbling sounds. As thus produced they belong to bronchitis, especially in the early stage, before the mucus becomes abundant. Spasmodic contraction of the muscular fibres of the bronchial tubes also gives rise to these râles in

a marked degree, especially the sibilant. This is the pathological condition in asthma; and the dry râles are often so loud in this affection as to be heard at a distance. As a rule, the sonorous râle is produced within the larger, and the sibilant within the smaller tubes.

The dry, as well as the moist, bronchial râles are apt to be fugacious, being present at this moment and absent the next. This is true of them as they occur in bronchitis, but in asthma they are more persisting. That they are due to spasm in the latter affection is proved by the rapid disappearance—even in a few moments—in certain cases in which we succeed in procuring for the patient sudden and immediate relief, as sometimes happens, for example, under the use of chloroform by inhalation.

The single moist râle produced within cavities is well described by its name. It is called gurgling. This term gives the idea as well as any lengthened description could do. It is a gurgling sound produced by the agitation of liquid and large bubbling within a space of considerable size partially filled with liquid. It occurs sometimes, under these conditions, in a tuberculous cavity, which communicates by large openings with the bronchial tubes. It is quite distinctive of a cavity.

The single dry râle produced within the air vesicles is a highly important sign. It is, of itself, more diagnostic of a particular disease than any other one of the physical signs. In fact it may be considered as almost pathognomonic. It is called the crepitant râle. The true crepitant râle is the sign of pneumonia. The instances are few in which it is not a sign of this disease; but it is not invariably present in cases of pneumonia.

The distinctive characters of the crepitant râle are well marked and simple. Bearing them in mind, after you have had a few illustrations of the sign, you will never have any difficulty in recognising it. What are these characters? The sound is dry; it conveys no impression of moisture. It appears to be made up of a great number of dry minute cracklings. In both these particulars it differs from the only sign with which it is liable to be confounded, viz. the subcrepitant.

The subcrepitant râle approximates in its characters to the crepitant, and here is the reason of its having been called the subcrepitant râle. But it is a moist bronchial râle, and it appears to be composed of minute bubbles of unequal size. There are, however, other distinctions, one of which is very important. The true crepitant râle is heard only in inspiration, never in expiration, while the subcrepitant may be heard in either act and in both acts. If, therefore, a sound, concerning which you may have doubt, be heard in expiration, it must be a subcrepitant râle. Another point of distinction is, the crepitant râle is quickly evolved, like a flash of gunpowder, to which it has been compared, while the subcrepitant râle is developed under the ear more slowly. Another point is, it persists for a certain period, and is not fugacious like the moist bronchial râles.

We may define the true crepitant râle in a few words by saying that it has a dry crackling sound heard only in inspiration. Why is it thus dry, and limited to the inspiration? This question leads me to state the mechanism of this sound. In general, gentlemen, as you have observed, I have said very little respecting the mechanism of the auscultatory sounds. This branch of the subject is not without interest and importance; but I repeat what I have said before, the practical value of physical exploration does not depend on our ability to offer correct explanations of the manner in which the phenomena are produced. The diagnostic significance of the signs rests wholly on the results of clinical observation, in connexion with the results of examinations after death. And in the limited time allotted to these lectures, I wish to treat of the subject wholly in a practical view. Were I to enter into discussions relative to the mechanism of the signs, I should feel, much more than now, the difficulty of compressing into this short course of lectures the practical information which I desire to give.

Concerning the mechanism of the crepitant râle, however, I will say a few words, because I am satisfied that the explanation generally given is erroneous, and, moreover, the true explanation, as I believe, was given by one of our countrymen, Dr. Carr, of Canandaigua, in this state, in a communication made to the *American Journal of Medical Sciences* more than twenty years ago.

The explanation generally given of the crepitant râle is, that it is produced by minute bubbles in the air vesicles and capillary tubes. Now, if this were the correct explanation, why should the sound be perfectly dry, as is the fact? Again, why should not the bubbles be produced by the air in expiration as well as in inspiration, as is the fact with the bubbling sounds elsewhere in the air passages? Dr. Carr's explanation is not only sufficient to account for the sound, but it accords with all the facts pertaining to it. His explanation is as follows: In the first stage of pneumonia a viscid adhesive exudation takes place into the air vesicles and capillary tubes. This we know to be the fact; it is this exudation which gives the viscosity or adhesiveness to the characteristic expectoration in this stage of pneumonia. Now, at the end of the expiratory acts, the walls of more or less of the air vesicles and capillary tubes are glued together by means of this sticky substance, and, when separated by the act of inspiration, the separation causes the crackling sounds. The râle can be imitated most perfectly by placing between the index finger and thumb a little paste or solution of gum, and alternately pressing and separating the surfaces near to the ear. This explanation accords with the fact of dryness of the sound; with the fact that the minute cracklings appear to be equal; with the fact that the sound is evolved quickly, and sometimes limited to the end of the inspiratory act; with the fact (which I have not before stated) that the râle belongs especially to the first stage of pneumonia; and lastly, with the fact that it is heard only in inspiration.

Laennec did not ascertain all the characters which distinguish the crepitant râle, and hence he confounded the crepitant with the subcrepitant. This led him to describe the crepitant râle as generally returning in cases of pneumonia during the stage of resolution. It does sometimes return in this stage, and it is then called the crepitant râle redux; but, in general, it is the subcrepitant, not the true crepitant râle, which is heard during convalescence from pneumonia. As I have stated, the crepitant râle is the sign of pneumonia. If, in connexion with symptoms pointing to this disease, we find this râle well marked, the diagnosis is complete. But, I repeat, the râle is not always present in cases of pneumonia. It is, however, much oftener present (at all events in cases of pneumonia in this country) than is stated by Skoda, of Vienna. Skoda states that it is rarely present in pneumonia. It belongs especially to the first stage of the disease. It either ceases, or is greatly diminished, when the exudation is sufficient to fill the air vesicles and solidify the lung. Again, it may reappear as the exudation goes off.

Let me point out the circumstances under which this sign may be produced, with a few inspirations, when pneumonia is not present. If a feeble patient have lain upon the back for some time, breathing feebly, and he be suddenly made to assume the sitting posture, and to take a full inspiration, we obtain often a well marked crepitant râle. It continues, however, during a few forced inspirations only. The explanation is, the lungs having been but little expanded for some time, the walls of more or less of the cells and capillary tubes have become agglutinated sufficiently to give rise to the sound when they are separated by a full expansion of the lungs. I have known repeatedly an erroneous diagnosis of pneumonia to be predicated on the sign as thus produced. It is important then to observe whether the sign, when it occurs under these circumstances, be transient or persistent. It is generally also, under these circumstances, heard on both sides, while in the vast majority of the cases of pneumonia it is limited to one side.

A crepitant râle is sometimes heard within a circumscribed space on one side of the summit of the chest. It then proceeds from a circumscribed pneumonia, which is, in general, evidence of a deposit of tubercle. Under these circumstances, the crepitant râle becomes, inferentially, a sign of tuberculosis. The same is true of a subcrepitant râle. If the latter be confined within a circumscribed space of the summit of the chest on one side, it denotes a circumscribed capillary bronchitis, or the presence of liquid in the small capillary tubes, within the circumscribed space; and clinical observation shows that this is apt to occur in cases of tuberculosis, and rarely save in that connexion. These belong to a group of accessory signs of tuberculosis, which are sometimes of much practical value in the diagnosis of that affection.

In my next lecture (which will be the last of my present course) I shall notice two additional râles, and consider the vocal signs obtained by auscultation.

tus. Although we have applied it more than twenty times, and in every case directly against the integument, yet in no instance has it given rise to any undue pressure over the malleoli or heel—points which are apt to trouble the surgeon considerably. Another interesting feature may be stated, that it has never produced any excoriations, but, on the contrary, in several instances where it has been applied over denuded surfaces, it has apparently exercised a healing effect.

Its advantages over the starch bandage are its rapidity of drying and hardening, the plaster taking about five minutes "to set," while being held by the surgeon in its proper position; the starch apparatus requiring several days to dry unless artificial heat is applied. Another advantage is, that the limb can be inspected daily if necessary, without removing all the apparatus. It, therefore, can be applied much earlier than we have been in the habit of resorting to the starch bandage. It may be well to state that the starch apparatus has been generally used in this institution only after the fracture has become tolerably firm, since in several instances where it has been applied early in the treatment, marked deformity has resulted. But the plaster of Paris casing allows the anterior surface of the limb to be exposed, and any displacement can consequently be readily detected.

Its advantage over the gutta percha is its great porosity, keeping the limb perfectly dry without confining the perspiration, and thus doing away with one cause of irritation and excoriation. It does not require padding like the gutta percha, and it is much cheaper, an important item in hospital practice.

The mode of application to the leg is as follows:—The limb is first shaven or slightly oiled; a piece of old coarse washed muslin is next selected of a size so that when folded about four thicknesses it is wide enough to envelop more than half of the circumference of the limb, and long enough to extend from a little below the under surface of the knee to about five inches below the heel. The solution of plaster is then to be prepared. Fine, well dried, white plaster had better be selected, and before using a small portion should be mixed with water in a spoon and allowed "to set," with a view of ascertaining the length of time requisite for that process. If it is over five minutes, a small quantity of common salt had better be dissolved in the water before adding the plaster. The more salt added, the sooner will the plaster "set." If delay be necessary, the addition of a few drops of carpenter's glue or mucilage will subserve that end. Equal parts of water and plaster are the best proportions. The plaster is sprinkled in the water and gradually mixed with it. The cloth, unfolded, is then immersed in the solution and well saturated; it is then to be quickly folded as before arranged and laid on a flat surface, such as a board or a table, and smoothed once or twice with the hand in order to remove any irregularities of its surface, and then, with the help of an assistant, applied to the posterior surface of the limb. The portion extending below the heel is turned up on the sole of the foot, and the sides folded over the dorsum and a fold made at the ankle on either side, and a roller bandage applied pretty firmly over all. The limb is then to be held in a proper position (extension being made if necessary by the surgeon), until the plaster becomes hard. The time required in preparing the cloth, mixing the plaster, and applying the casing to the limb, need not take more than fifteen minutes. After the plaster is firm and the bandage removed, we will have a solid plaster of Paris case partially enveloping the limb, leaving a portion of its anterior surface exposed to view. If any swelling occurs evaporating lotions can be applied to the exposed surface, and we can always easily determine the relation of the fractured ends. If necessary an anterior splint, made of the same material, can be applied, and then both bound together with adhesive plaster, and if desirable a roller bandage over all. If the anterior splint is not used, two or three strips of adhesive plaster, one inch wide, or bands of any kind, may be applied around the casing, and will serve

Original Communications.

THE TREATMENT OF FRACTURES BY PLASTER OF PARIS SPLINTS.

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THE use of plaster of Paris in the treatment of fractures dates from a very early period.

Eaton, an English consul at Bassora, about the close of the last century, saw it employed by the Arabians. It was first employed in Europe by Hendrikens, at the hospital of Gröningen, in 1814, and afterwards by Hubenthal, Kyle, and Dieffenbach.

By these surgeons it was used in a very clumsy manner. Dieffenbach poured the plaster over the limb, so as to inclose it in a solid casing; and it was necessary to use the hammer and chisel, in order to break the mould to remove it, thus jarring the limb and running the chances of injuring a newly consolidated fracture. These moulds have been justly called by Hamilton "heavy stone coffins, they might serve well enough the purpose of interment, but they are wholly unsuited to the purposes of a splint." A. Pirogoff, of St. Petersburg, in the year 1854, published a monograph on a new method of bandaging fractured limbs with linen soaked in a solution of plaster of Paris. His method was as follows:—The limb was first bandaged and the depressions filled with raw cotton, then splints of the coarsest linen saturated in a solution of the plaster were applied lengthways to the limb, and fastened crossways with strips saturated with the same material. Dr. Weber, of this city, reported a case treated in this manner in the *New York Journal of Medicine*, for May, 1856. Other similar methods have also been recommended. Bandages with the meshes filled with dry plaster have been applied to the limb and then wetted with cold water; the plaster hardening in a few minutes, formed a solid casing for the limb.

But all these methods had fallen into disuse, until recently, when Maisonneuve, of Paris, revived the use of this substance in the construction of splints for fractures. His method of applying it is somewhat similar to that of Pirogoff, and has been fully described in former numbers of this journal by Drs. Smith and Swan, in their letters from Paris. About three months ago it was applied for the first time in the New York Hospital, in a way somewhat different from that of the French surgeon. It answered the purpose so admirably, that its use was followed up until now it has almost entirely supplanted the starch bandage, and in many cases the side splints. Its advantages are; its facility of application, and its perfect adaptation to the limb, being borne by the patient better than any other form of appara-

to keep it firmly adjusted to the limb. Thus applied, we have a most beautiful splint, partially enveloping the limb, making equal pressure, light, and allowing the patient to change his position in bed, or to sit up in a chair, or go about on crutches; and a splint which can be easily made in any place where plaster is to be had.

This mode of dressing may be applied with great advantage in most cases of fractures of the tibia and fibula. In oblique fractures of the tibia with the projection of the superior fragment, it is well known how difficult it is to overcome the deformity; with the plaster of Paris splint, however, the results have been all that could be desired. After extension of the limb on the part of an assistant for the sake of bringing the fragments into perfect apposition, and while thus held, the plaster splint should be applied and allowed to harden.

The limb is thus perfectly immovable. A strip of two or three thicknesses of muslin, about three inches wide, saturated with the plaster, may be applied transversely, if necessary, over the upper fragment so as to bind it down in position. The cases in which this mode of dressing is not applicable, are those of fracture of the fibula with rupture of the internal lateral ligament, or, what is more common, a chipping off of a portion of the internal malleolus with the turning of the foot outwards. Where the deformity is considerable it cannot always be overcome at once, but requires steady pressure, with properly arranged pads, and the side splints, to bring out that result. This effected, to a certain extent, the plaster apparatus may be applied with advantage. In cases of fracture of the fibula, without any displacement of the foot, it may be applied early in the treatment; upon the entire subsidence of the swelling it will become necessary to apply a new one. This second dressing in most cases will be sufficient for the remaining treatment. The following cases of fracture will serve to illustrate the applicability of this new apparatus.

CASE I.—Ununited Fracture of the Leg.—Francis Wyncoop, et. 26, admitted May 19 (Dr. Buck, attending surgeon), with a compound oblique fracture of right leg, at the lower third. The wound was very small, and situated on the inner side of the limb. Leg was placed in fracture box, and wound covered with lint and collodion. The wound closed, and for about three weeks the case progressed favorably. At about the commencement of the fourth week the wound opened afresh. At the end of the twelfth week no union had taken place, and the wound was filled with exuberant granulations, and a free discharge kept up. The bone was not exposed. August 13, the limb was placed in the plaster of Paris apparatus applied next to the integument, and a small fenestrum made over the wound so as to allow of its being dressed without removing the splint. Patient was able to get up, and in a short time regained strength enough to go about on crutches in the open air. From this time the fracture began to unite, and on October 26 he was discharged cured. In this connexion, it may be remarked that no complaint was made of any undue pressure over the salient points of the limb.

CASE II.—Benjamin Witwitz, et. 44, admitted August 16, 1861 (Dr. Parker, attending surgeon), with an oblique fracture of both bones of the left leg at the junction of the middle and lower thirds: the line of fracture was from within upwards and outwards. Limb was placed in a fracture box and evaporating lotion applied. On the fourth day, the swelling being very inconsiderable, the plaster splints were applied, the limb being held in the proper position while the plaster hardened. The next day the patient was allowed to get up, and go about on crutches. Although this was applied so soon after the accident, still there was no complaint on the part of patient. Patient was discharged cured on October 1, without any deformity.

CASE III.—Mary J., et. 30, admitted October 16 (Dr. Buck). Patient while intoxicated was pushed from a stoop and sustained an oblique fracture of left tibia, at about the middle. The fracture of the fibula was about two inches above that of the tibia. Limb, at first, was

placed in fracture box. On the fourth day after the injury the plaster splint was applied, and it remained on until patient was discharged. At time of discharge union was firm, and there was no deformity.

CASE IV.—Jas. Lockwood, et. 43, admitted Nov. 1 (Dr. Buck), with fracture of tibia at lower third, and fibula at upper third. Plaster splint applied on fifth day, and patient next day was up on crutches. Same dressing remained on until union was completed. No deformity.

The following cases have been kindly furnished me by Dr. D. B. St. John Roosa, of the second Surgical Division, who, by permission of the attending surgeon, applied the apparatus in accordance with the rules previously laid down.

CASE V.—Fracture of Fibula and Tibia.—John H., et. 25, Ireland, admitted Oct. 6 (Dr. Watson). A few moments before admission, fell from a window, a distance of about eighteen feet; force of fall upon right leg. There is found a fracture of the fibula, about four inches above the lower end, also a chipping off of the internal malleolus. Deformity slight. Placed in fracture box. Oct. 10, placed in plaster of Paris splint. In a few hours after, the patient was up and about. Oct. 23.—Fracture has united; patient now bears weight of his body on the part. Nov. 4.—Splint removed; no deformity; discharged cured.

CASE VI.—Fracture of Tibia and Fibula.—Boy, et. 8, admitted September 12 (Dr. Buck). Heavy stone fell on the left leg; fracture of tibia; junction of middle and upper third; line of separation, oblique from within upwards and outwards. Fibula also fractured at a point one inch below. Treatment: placed in fracture box; remained in till September 20; side splints applied, and on October 1, eighteen days after injury, when slight union had occurred, plaster of Paris splint applied; and patient immediately went about on crutches and continued to do so until October 25, when he was, with firm union and no deformity, discharged. Here it would be fair to state that the apparatus would have been applied earlier had attention been called to it.

CASES VII. and VIII.—This surgical expedient has also been used in two cases of compound fracture of the leg. The first, a young man, et. 23, admitted November 16, having sustained his injury by being partially buried beneath a bank of earth. On examination there was found a compound fracture of the left tibia and fibula at about the junction of the lower with the middle third; fracture, oblique from within upwards and outwards. The wound was nearly transverse, one inch in length, exposing the bone, and situated on the inner side of the limb opposite the fracture. The finger could be pushed under the integuments for about three inches above the wound; hemorrhage quite free. The wound was closed and covered with a piece of lint saturated with collodion, and the limb placed in the fracture box until the visit of Dr. Buck, the attending surgeon, and by his request the plaster splint was applied, no swelling to any extent having yet occurred. After its adjustment the patient expressed himself warmly in favor of the comfort of the apparatus. The evaporating lotion was applied to the anterior exposed surface of the limb. By this splint the most essential indication in the early treatment of compound fractures was fulfilled, namely, the perfect quietude of the limb. The foot being firmly clasped by the splint, no motion of any amount could be communicated to the fracture. Six days after the injury, the lint over the wound was removed and a healthy granulating sore was found; no undue inflammation or swelling existed around it. This case is still under treatment and doing well; no suppuration except from surface of sore; no burrowing.

The other case (VIII.) was that of a man aged 51, admitted November 21, with a very oblique compound fracture of the tibia and fibula. The obliquity was without, inwards and downwards. The wound was very small, and situated over the inner side of the limb opposite the fracture. The swelling was very considerable. The wound was closed with lint saturated with collodion,

and the limb placed in a fracture box. During the night the muscular spasm would displace the fracture, and cause the lower end of the upper fragment, which was very sharp, to push against the integument, threatening perforation, causing the patient considerable pain. On the second day, by permission of Dr. Buck, the plaster splint was applied, and two strips of muslin of four thicknesses and about three inches in width were saturated with a solution of plaster and applied over the upper fragment, binding it down into position. Cooling lotions were applied over the exposed surface of the limb. This dressing brought the limb into pretty good position, and afforded considerable comfort to the patient. At the suggestion of Dr. Buck the limb thus dressed was placed in a bran bed made in a fracture-box, and thus still more secured from all motion. On the fourth day the swelling subsiding, the splint became loose, and allowed the lower end of the superior fragment again to press against the skin. New dressings were applied, and a strip of muslin of six thicknesses placed lengthwise over the anterior surface of the upper fragment, and bound down by a strip of four thicknesses, about three inches wide, passing around the splint. This seemed to keep the fragment from projecting. This case is now doing well.

In fractures about the knee-joint and in cases of *synovitis* where a posterior splint or knee-cap is needed in order to keep the limb in a straight or semi-flexed position, this mode of forming a splint can be made use of and answers better than the gutta percha. We have applied it to one case of *synovitis* after the acute symptoms had been subdued by the means of extension and counter-irritation, and it formed a very good posterior splint. In fractures of the *tarsal bones* it may likewise be used with advantage. Here it should be long enough to envelop the foot as far up as the toes.

The two following cases of *fracture of the astragalus* have been treated in this manner with good results.

CASE IX.—Mary Walker, æt. 21, admitted August 31 (Dr. Parker), patient a short time before admission injured her left foot while going down stairs. She had been treated outside by the application of poultices. On admission there was so much swelling about the part that a correct diagnosis could not be made; cooling and anodyne applications were used, and after the swelling had subsided bony crepitus could be distinguished, apparently between the malleoli, on moving the foot. The limb was placed in a fracture-box, and the foot well supported by the foot-board. On October 3, the plaster apparatus was applied so as to partially envelop the foot, thus keeping it immovable; patient allowed to go about on crutches. October 22.—Apparatus removed; no crepitus could be made out; foot somewhat stiff; limb bandaged, and patient directed to begin using it with the aid of a crutch. She was discharged November 18; able to walk upon the limb without external assistance.

CASE X.—John Cunningham, æt. 24, admitted September 22 (Dr. Parker), having jumped from a third story window to the pavement while in a fit of delirium tremens. On admission both malleoli were found intact; patient complained of pain on pressure over the astragalus, and on moving the foot crepitus was distinctly felt; limb placed in fracture-box, and evaporating lotion applied. Patient soon became so delirious that it was necessary to remove him to the delirium tremens ward. After he had recovered from this affection and the swelling had subsided, it was carefully examined by Dr. Buck, and the diagnosis verified. The plaster casing was then applied, and patient allowed to go about on crutches. November 2.—He was discharged cured, able to walk with the assistance of a cane, though it may be proper to add that the joint was somewhat stiff.

For *fractures of the lower jaw*, it can be made use of to construct a splint in the usual manner.

In *fractures of the neck of the humerus*, where a shoulder splint, as recommended by Hamilton, is necessary, this may be made use of; it would make a much better and cheaper splint than the gutta percha, and it would fit the

shoulder more accurately than any wooden splint that could be made.

In *fractures of the shaft of the bone* it may also be used. It should be long enough to extend from the shoulder to the hand, and applied to the outside of the limb, the limb being flexed to a right angle, and extension being made so as to keep the fragments in position until the plaster "sets." If necessary, a small splint made of the same material can be applied to the inner side of the arm, and both bound together with a bandage. The limb, of course, is to be placed in a sling.

CASE XL.—*Fracture of both Humeri.*—Jas. Merrian, æt. 45. Admitted Nov. 1 (Dr. Buck) with a fracture of both arms, and fracture of several of the ribs and various contusions about the body. He received his injuries in consequence of having been buried in by the caving of a bank of earth. Both humeri were found fractured obliquely about their middle. Arms at first placed in guttered tin splints. On the fourth day after admission, and the sixth day after the accident, plaster of Paris appliances were resorted to and made to reach from the shoulder to the hands. As patient was compelled from his other injuries to remain in bed, the arms were placed in a slightly flexed condition. The splints reached a little more than half way round the arms. A small splint was made of the same material, which was applied to the remaining inward surface of the arm, and bound on with a bandage. At the end of the second week the splints becoming loose by the subsidence of the swelling, new splints were applied. Thus far the case has progressed favorably.

For *fractures at the base of the condyles*, and other fractures in the vicinity of and involving the elbow-joint, which require the arm to be kept in a flexed position, this is decidedly the best mode of dressing. For this purpose angular splints made of tin, gutta percha, or pasteboard, are commonly used, and all require some little time for their construction. The plaster of Paris splint can be made in five minutes, and will fit itself to the inequalities of the arm more accurately than any other.

Fracture at Base of the Condyles.—Christina Chapman, æt. 4 years, admitted Sept. 5, 1861 (Dr. Parker), fell from a stoop, and sustained a fracture of the humerus at the base of the condyles. The deformity was the projecting backwards of the lower end of the upper fragment, resembling a dislocation backwards of the radius and ulna; crepitus distinct. The fracture was reduced, and limb laid on a pillow, and cooling applications applied. On the seventh day, the swelling having subsided, the arm was put up in a plaster of Paris splint, in a position a little more than a right angle, the splint reaching from the shoulder to the hand, and more than half way round the arm. This was firmly applied with a roller—limb held in position until the plaster "set," and on hardening, formed a perfect elbow splint, keeping the fractured ends in perfect apposition. This was removed on the third week, and an examination made, which showed that union was firm. Passive motion was then commenced, and continued daily, the limb being replaced in the same splint. In a short time she entirely regained the use of the joint.

Although we have had no opportunity of witnessing its application in cases of *club foot*, we may venture an opinion that no better shoe could be constructed, and none which would fulfil more indications after tenotomy has been performed, than by these accurate mouldings to the limb. During and for a while after the application of this dressing, due attention should be paid to adjustment of the foot. The gutta percha shoe, which is more troublesome to make, and certainly in many respects not as good, might thus be dispensed with.

Without seeking to lay any undue stress upon the value of this mode of dressing, in which we think we have been borne out by the successful issue of the cases above detailed, we still think ourselves justified in recommending it in all instances where despatch is an object worth striving after.

Many valuable lives, perhaps, might be saved, and much suffering certainly alleviated upon the battle-field, by a resort to this expedient. No great amount of surgical skill is requisite for its use, and not much room need be taken up in the packing away of the plaster in its dry state, proper care, of course, being taken to prevent the contact of moisture. Again the art of its application, if such we may style it, can be very readily communicated to any of ordinary intelligence, such, for instance, as those presumed to compose an ambulance corps. Patients with limbs dressed in this manner might be transported comfortably.

In conclusion, we would disclaim any originality in our views, having first received hints upon the subject from a description of M. Maisonneuve's method, as set forth in the letters of Dr. D. P. Smith to the *American Medical Times*. There may be certain modifications in the application of the plaster, but to this distinguished French surgeon belongs the credit of reviving its use and urging its adoption upon the profession.

HERNIA.

CAUSES OF ITS FREQUENCY—MEANS OF PREVENTION—POLICY AS REGARDS ITS TREATMENT.

By J. W. RIGGS, M.D.

IN a report submitted to the American Medical Association a few years since, by a committee of distinguished surgeons chosen by the Association to investigate the subject of hernia, the following language occurs:—"Either there is some inherent difficulty in the way of the radical cure of hernia, or the proper method has not yet been discovered." These views seem to have met with the concurrence of the medical profession very generally, and are believed to be in accordance with the prevailing sentiment of the present day; and even had this report been made still more humiliating by stating that hernia is not only irremedial, but is usually aggravated by the means ordinarily employed, such statement would have been amply sustained by the testimony of at least a large majority of all who have had adequate experience with trusses.

If the observations and researches of a Hayward, a Warren, and a Parkman, lead to such conclusions—and if, moreover, it be demonstrable that the usual treatment of hernia is oftener injurious than otherwise—it will not be deemed too soon to invite further attention to the disease and its treatment, with the hope of attaining ultimately to better results.

Indeed, had physicians given this subject more attention at a much earlier day, it is not to be doubted that, as a rich reward for their labors, a vast amount of suffering would have been avoided, and many valuable lives saved to the world.

In an article on congenital hernia, which appeared in this journal in April last, the reader may have noticed the remark, that this disease (occurring in infancy), unless speedily cured, is believed to predispose its victim ever after to a return of the malady; and, moreover, that when consecutive ruptures (or relapses) do occur, they always differ essentially from primary herniae, and cannot be treated with that reasonable hope of success which may always be entertained when the disease has not previously existed in the same individual.

If the arguments advanced in support of this position are valid, the inference is, that a very large proportion of the ruptures now existing in the adult population of the world, with its concomitant suffering and death, may be traced to a mistaken policy as regards its management during infancy and childhood. An exact estimate of the proportions cannot be given, but to say that one half the ruptures now existing in adults will be found in those who had had the disease early in life, would be far from an exaggeration; and hence it follows, according to the theory advanced, that by proper treatment at the proper time, an untold and

inconceivable amount of suffering and of death from this disease would have been averted.

"Just as the twig is bent the tree's inclined," is not less true of animal than it is of vegetable growths; and if the inguinal canal be dragged down, overstretched, and distorted by the intruding bowel for months and years during the tender periods of infancy and childhood, no human agency can restore this passage to its normal condition, nor even to such an approximation towards its natural state as to afford exemption or scarcely the hope of escape, from a return of the disease at some future day.

Nor is it at all strange that the application of trusses, especially to young subjects, is so utterly barren of good results and oftentimes hurtful, for, as is well known, these instruments are employed usually without discrimination—without any adequate knowledge of the laws of cure or of the indications to be fulfilled, and without the slightest regard to fitness in any respects, either as to the principle or construction of the instruments, the amount of pressure to be exerted, or the situation it should occupy in order to support and maintain the obliquity of the canal. So also is it abundantly manifest that the unsatisfactory treatment of the disease in adults is mainly attributable to the various causes above mentioned.

Though the mere existence of hernia, whether in the child or the adult, does not necessarily involve the same amount of physical suffering that is sometimes experienced in other cases, yet there are few diseases more dependent upon the intelligent use of suitable means for their successful treatment, or of more importance than that under consideration.

The Indications.—Prominent, and among the first of these, is to prevent the escape of the viscera. And it may here be remarked, that this important requirement is rarely fulfilled by trusses; either the construction or application of the instrument being such as to render its accomplishment in a satisfactory manner entirely impracticable. Though the bowel may for the most part be retained within the abdominal ring (?), it usually occupies the internal aperture and upper portion of the canal, and escapes at its outlet immediately on the removal of the truss, as well as too frequently, also, with the instrument in its accustomed position. As was stated on a former occasion, *the bowel cannot be effectively retained by the ordinary convex pad of the usual size when properly placed above the pubes*, for when thus situated, as it always should be, and as, in order to afford any reasonable hope of permanent benefit, it must necessarily be, the greatest care seldom suffices to prevent its escape.

It is not only necessary that the protrusion of the viscous at the external ring be carefully guarded against *at all times*, but to afford any reasonable hope of cure the passage must be kept so closed *throughout its course* as not to admit the intestine at the internal ring. Nor is the mere closure, or obstruction of the canal, however perfectly accomplished, all that is required. There is a right and a wrong way of effecting this object—a method which never fails of good results, and other plans which, on the other hand, very seldom fail of disastrous consequences to the patient.

If there are physicians who, from inattention to the subject, are unaware of the fact, there are comparatively few among the victims of hernia who have not learned by a sad experience that usually, with the increased duration of the disease, there is a corresponding augmentation of suffering, and this is believed to be too often only the legitimate effects of treatment.

Besides the absorption of tissue, impingement of the spermatic vessels, and enlargement of the apertures, incident to the ordinary convex truss pad, this form of the instrument, when in its proper position, favors the escape of the bowel, as stated, more than any other that could be devised. Not only is this shape objectionable for the reasons mentioned, but its liability to displacement with the constant shifting of the integuments, to which alone it attaches itself, contributes largely to its inefficiency.

It is true, this pad may be made so conical or so pointed as to bury itself to a considerable extent in the subjacent muscular tissues and thus maintain its position. But it must be borne in mind, that besides the discomforts thus occasioned, the nicest discrimination as to the amount of pressure and position of the instrument rarely prevents undue stretching and enlargement of the hernial apertures. Especially are these evils to be dreaded (if they are not inevitable), unless the abdominal walls are well developed and unyielding to pressure.

Dr. Valentine Mott called attention many years since, to some of the foregoing evils resulting from trusses, and urged upon the late Dr. Hull, whose truss was the most extensively employed, the importance of changing his instrument from its then convex, to its present concave form. In his notes to "Cooper's Dictionary," the late Dr. Reese also advocates this principle. And if proof were wanting of the wisdom and far-seeing sagacity which first suggested this improvement, a comparison of the results of treatment by this, with those by the ordinary convex truss, will abundantly suffice by showing, unmistakably, that a vast amount of evil has been averted by this change.

(It is deemed proper here to allude briefly to the multipedal or knobbed truss pad. This instrument, suitably adjusted, exerts lateral pressure upon either side of both the external and internal openings, thus approximating the walls of the passage without obstructing the circulation in the cord, and in such manner as to force the intestine into its position within the body, where it may and always should be maintained. It will be observed that in this case, the force of the spring, instead of being exerted at a single point, is distributed equally upon separate bearings, thus making the instrument not only comfortable to the wearer, but also immovable by the various motions of the body—whilst, also, the evils above mentioned are effectually obviated, and every indication of treatment fulfilled as perfectly, it is believed, as is practicable by any mechanical contrivance.)

Pressure by the Truss.—Though remarked on a former occasion, it will well bear repetition here—that the importance of a just discrimination as regards the force exerted by truss springs cannot be over-estimated. Much of the irreparable injury by trusses as may be due to other causes, nothing is so prolific of mischief in most cases as the long continued application of undue force by a convex or conical pad.

The impossibility of graduating the force of a tempered steel spring, and of adjusting it nicely to the form of the body, has been a great obstacle to the proper adaptation of trusses, and thus more or less productive of evil. The hard rubber, as now applied to truss springs, effectually overcomes these difficulties. Simply by immersing the spring for a moment in boiling water, and thus heating the rubber to prevent its fracture during the necessary manipulations, it may be moulded to any desired form, and the pressure be increased or diminished with the utmost exactness, without in the least impairing its suppleness or elasticity. Whilst, moreover, the perfect insulation of the steel by this inimitable material excludes all moisture, and renders the instrument perpetually cleanly and durable.

The instrument itself being properly constructed and so adjusted as to afford adequate support to the passage throughout its course—and without injury to the patient—it becomes necessary and indispensable to success that the efficiency of the truss be carefully maintained. It were needless to repeat that the greatest precaution should be observed to guard against protrusion of the bowel *at all times*. Not only should the passage be closed against the intestine, but the sac itself should be entirely excluded from the inguinal canal.

Another and by no means less important prerequisite to success in this disease, is *its supervision by the medical attendant*. At least the occasional attention of the surgeon is demanded as much in this as in any case of mechanical surgery. However philosophical the instrument employed,

and however perfect its adaptation to the case when first applied, instances seldom or never occur in which as regards its practical working it is not sooner or later found susceptible of improvement. The most limited experience with trusses could hardly fail to demonstrate this fact, by showing, for instance, that the force which is only adequate to the perfect retention of the bowel at first, might, by too long continuance, especially with the convex pad, prove disastrous by such extensive absorption and attenuation of the parts as to render enlargement of the hernial apertures inevitable. It is found necessary also in most cases to modify the form or the size, or perhaps change the position of the rupture pad during treatment, not only to avoid any threatened evil, but to maintain and if possible enhance the curative tendencies of the instrument.

There are many reasons in favor of the policy here advocated, which on due reflection will suggest themselves to the mind of every professional reader, and which would seem to be conclusive on this point.

In fractures, as well as all other surgical cases, the attentions of the surgeon are very properly deemed indispensable until a well established convalescence renders them no longer necessary. So fixed and so inexorable in its demands has this rule become, that in view of the fearful responsibilities justly devolving upon him, and of the consequences to his patient (and perhaps to himself) of any flagrant or habitual neglect, the practitioner very rarely fails to make available all the means at his command for the proper fulfilment of at least some of the more prominent indications of treatment; and until like rules obtain for the management of this disease, all experience of the past demonstrates too clearly that little else than failure and disaster are to be hoped for in the future.

It will scarcely be urged that the interests at stake are not of sufficient magnitude to demand the physician's care and attention—for these, whether sanitary, pecuniary, or social, when viewed in the aggregate, are believed to be vastly greater than are involved in any other disease.

Neither will it be said in vindication of the let-alone policy hitherto observed by the profession, that owing to a want of the necessary appliances for every emergency, physicians cannot treat hernia satisfactorily. With equal plausibility and like force it might be urged in case of a fractured bone for instance, or of a severe injury demanding amputation, that in the former the patient must be maimed for life, and in the latter die a premature death, because forsooth his medical adviser or surgeon had not the means necessary for his deliverance.

It may be observed, moreover, that in every department of the healing art there is an important though latent element largely available in the treatment of disease, and which, in hernia especially, finds unlimited scope for the display of its magical potency; and this can be recognised and duly appreciated only by the medical practitioner. It is that conservatism which happily is so rapidly gaining favor, and may well be said to characterize and not less to distinguish and adorn the professional career of every true physician.

It is well known, for example, that in very many families the openings through which the bowels usually escape in hernia are preternaturally large: and that in all these there may be said to exist a positive predisposition to the disease. So true is this doctrine of the transmissibility of disease, as regards this infirmity, that instances are comparatively rare where the children of ruptured parents escape a like infliction. Knowing this fact then, which all alike do know—and with daily and hourly opportunities, such as all practitioners enjoy, whether it be regarded as an imperative duty or not—the physician would hardly transcend the functions of his heaven-born mission, under such circumstances, simply to impart to parents this knowledge of impending danger to their offspring, and thus arouse a sleepless vigilance which would at least lead to the early discovery of the disease, with such appropriate treatment, as could not fail to divest this relentless, life-long malady,

of all its terrors, and in a large majority of instances result in its perfect cure.

Nor is the value of such supervisory care of the surgeon to be estimated alone by the benefits which would always result from the judicious treatment of this disease on its first development. If it be true, as doubtless it is, that usually months and not unfrequently years elapse between the time of the entrance of the viscera at the internal ring and their escape at the outlet of the canal, it must be admitted that with the slightest knowledge of the nature of hernia, and of its causes and premonitory symptoms, the infirmity would often be discovered even before the bowel had emerged from beneath the external ring; and that suitable means thus early employed would effectually oppose its further descent, and ultimately accomplish a radical cure of the disease, will scarcely admit of a doubt.

But arguments in support of a proposition so self-evident as that *hernia, like all other diseases, demands the care of physicians*, need not be multiplied. The dark and unsatisfying retrospect of the disease testifies too clearly of the worse than negative results of treatment (if such it may be termed) in the past, and to any objections that may be urged against a policy so obviously just, as well as to every argument that might be offered, either in explanation or justification of the entire neglect by the profession of sanitary interests so vast—let the fitting response be heard in the urgent, ceaseless, and hitherto unavailing appeals for deliverance, from the numberless victims of this disease, and in the heart-rending cries of those called daily in different parts of our land, to mourn the sudden and untimely (if not needless) death of some friend, the early victim to strangulated hernia.

The profession are not expected to accept, as established facts, any mere opinions or unsupported theories, however plausible they may appear; and if in this is only manifested that prudent and commendable caution which is justly demanded in the investigation of disease and its treatment, neither, on the other hand, is there shown any special exuberance of philanthropy, nor undue zeal in a noble cause, nor yet any excess of duty even by the most critical examination of all theories that impose the slightest claim to consideration.

Though the past, as stated, has signally failed to point out the method by which hernia may be successfully treated, it has nevertheless clearly revealed the significant, though apparently unheeded and as yet profitless truth, that from a like policy in the future like results only may reasonably be looked for. This may well be regarded as an important revelation, for upon its acceptance or rejection, and corresponding action by physicians, is believed very largely to depend the preservation on the one hand, or the sacrifice on the other hand, of the comfort and happiness and the varied interests as well as lives of unnumbered thousands.

It is barely possible, perhaps, that under the most enlightened and salutary *régime*, and with the most ingenious and philosophical appliances for the purpose, hernia could not be treated with that uniform success that attends suitable treatment in most other surgical diseases. Such, at all events, appears to be the opinion of the profession everywhere, and if past experience may be relied upon for the purpose, its verification is indeed most ample. It will be borne in mind, however, that, even in medicine, error has been known to exist and for a long time to prevail over less apparent truth; and it is, therefore, an undoubted right to question whether the prevalent opinion that hernia is irremediable, may not after all be considered a *theory* wholly unsupported by facts, rather than an unalterable decree. Whether so or not, there are those who will thus regard it until at least some more rational method of treating the disease than that hitherto usually practised shall have been fairly tested and found unavailing.

The treatment of this disease for years past, in accordance as nearly as was practicable with the views here advocated, and with not very limited opportunities for observation, forces upon the mind these convictions—

1. That hernia, even as it now exists, with all the disadvantages resulting from the want of proper management, may in most instances be materially benefited and often-times cured by judicious treatment.

2. That in children, and young subjects, such treatment, from its early stages, would almost invariably cure the disease; and instead of having, in consequence of its previous existence, incurred the certain liability to its recurrence in after life, such persons would be even less exposed than many who had not had the disease, nor used a suitable and well-adjusted instrument for support and protection early in life.

3. That this disease (both femoral and inguinal hernia) in adults, as well as in children, would generally be cured by proper treatment; and when not cured, would be so far remedied as to be free from suffering and from danger to the life of its victim. And whether to secure these results, and in time well-nigh exterminate the disease by the adoption of such policy as obtains in all other diseases, or (as heretofore) to leave it entirely to chance, and to be found in almost every family, is believed to depend wholly upon the medical profession to decide.

2 Barclay Street.

Reports of Hospitals.

NEW YORK HOSPITAL.

THREE CASES OF PRIMARY AMPUTATION.

CONCERNING the good results which respectively attend primary and secondary amputations, there has been a considerable difference of opinion, the reasons for which can be explained in a variety of ways. The military surgeon is proverbially more successful with his primary amputations than he who is engaged in civil practice. This, according to Ballingall, is accounted for in a great measure by the moral influences which relatively affect the two classes of patients. The wounded soldier loses his limb in a good cause, under circumstances which are highly creditable to himself, and for the sacrifice he is sure of a pension for life; his mind is comparatively easy. How different is the mental condition of the mechanic or the tradesman, who with perhaps an indifferent constitution, and a family dependent upon his exertions, is admitted with an injury requiring amputation, by which operation he finds himself suddenly deprived of his former means of subsistence. Another condition must be taken into account in this connexion, and that has reference to the physical change which each experiences in his new situation. The soldier, removed from the crowded camp or barrack-room to a well ventilated hospital, has an immense advantage, in being thus confined, over the out-door artisan who, save at night, is always in the open air. Then again, a great many operations have been performed upon the battle-field, which, were the surrounding circumstances different, the cases would have probably recovered without the use of the knife.

Viewing the other side of the question, a great many deaths occurring between the first and twentieth days have been charged to secondary amputation, to which, however, in truth they did not belong. Operations occurring thus in the intermediate period, are necessarily desperate as regards the promise of any good result, from the fact that they are performed at the most unfavorable period, and have for their purpose, not only the salvation of the limb, but of the very life of the patient. It is in consequence of the unfavorable results in such cases that Mr. Alcock, in common with the majority of surgeons, has advised primary amputation in all cases where there are serious doubts concerning the preservation of the limb. "Add," he remarks, "all these deaths (from *intermediary* amputation) to those from secondary amputation (properly so called), and

he must be a bigot indeed to the adverse opinion who can have one moment's hesitation as to which side of the question the amount of human suffering and the loss of life preponderate."

Aside from the general considerations which, all other things being equal, should urge the performance of primary amputations, statistics are decidedly in favor of the operation. The practice of the New York Hospital differs in no respect from that generally followed by other similar institutions.

The three following cases, communicated by Dr. D. B. St. John Roosa, Resident Surgeon of the Second Division, may serve as types of a class for which primary amputation is unhesitatingly performed.

CASE I.—Compound Fracture of Radius—Gunshot Wound.—Henry M., age 18, N. Y., printer, was admitted Aug. 20, 1861 (Dr. Buck, Attending Surgeon), at half past one P.M. A few hours previous, while getting over a fence, holding a shot-gun in his left hand, the muzzle resting against the palm, the trigger was caught, the gun discharged, and the contents lodged in hand and forearm. Patient was found somewhat agitated and anxious, very slight shock; pulse a little frequent, but of good force. The left arm was enveloped in bandages, on removing which the following appearances were presented:—There was a lacerated wound about one inch long, blackened with powder, situated at the base of the thenar eminence, the hole of entrance; and on the dorsal aspect of forearm, a lacerated wound, about the size of a three-cent-piece, the point of exit, through which shreds of wadding protruded. Patient was etherized, and a digital examination disclosed a compound comminuted fracture of the radius about three inches above the joint. Ulna intact, also radial and ulnar arteries. There was also situated just over the elbow a burn of a considerable degree of intensity, caused by the sleeve catching fire at the time of the accident.

In about one hour after admission, the forearm was removed at a point above the junction of the middle with the lower third by the circular operation. After the ligature of the bleeding points, the lips of the wound were united by interrupted silk sutures, and a wet bandage applied from above downwards. The patient passed a quiet night. The following day he had some slight fever, which was soon relieved by a purge. The stump looked remarkably well, and irrigation by means of a lamp-wick syphon was commenced. The second day after the operation the bandage was removed, when no tension of the stump was visible, neither was there any undue inflammatory redness present. The intermediate sutures were then removed, and the wet bandage reapplied. The irrigation, causing pain, was discontinued. On the 23d, the remaining sutures were removed, when there was a slight amount of suppuration at the edges of the wound. From this time the parts granulated nicely, and everything progressed favorably. The ulcer of the burn was dressed with simple cerate. On the 10th of October, he was discharged cured.

CASE II.—Compound Fracture at Elbow-joint—Railroad Injury.—J. C. D., policeman, aged 31, was admitted Sept. 4, 1861, during the service of Dr. Halsted, at 5 $\frac{1}{2}$ P.M. Three quarters of an hour prior to admission, while standing on a platform of a railroad car in motion, he attempted to jump off, and fell under the car; one wheel, revolving slowly, passed over his left arm. He immediately arose and walked to a carriage, wrapping his coat sleeve tightly around the limb. On admission, patient was calm and collected; pulse of good force. There being considerable hemorrhage from the arm near the elbow-joint, a tourniquet was applied over the brachial artery. On examination of the injury, there was found to be a compound comminuted fracture at the elbow-joint, with tearing up of integuments and laceration of muscles, to a point about three inches below shoulder-joint; the olecranon chipped off, lower extremity of os tricipitum comminuted, radius was proportionately shortened, and ulna was shattered throughout the upper third of its extent. In one hour Dr. Halsted had arrived,

meanwhile patient was stimulated with brandy and strong infusion of green tea. Patient was etherized, and the arm removed, by Alanson's method, at a point a little above the junction of upper with middle third. Ten ligatures were applied; stump was left open, supported on a pillow, and water dressings applied. Patient recovered slowly from anesthesia; took ten drops of liq. opii comp., and during night hypodermic injection of ten drops of Mag. sol. morph. Sept. 5th.—Was mildly delirious, owing doubtless to the fact of his having been a free liver for the last ten years. Stump was closed with silk sutures; water dressings continued; pulse 120; beef tea, in suitable quantities, ordered. 6th.—Slept only tolerably, with aid of sixty drops liq. opii, in two doses. Delirium continues; stump looking well; took beef tea, as before, and four oz. brandy per diem, and, besides, the following: B Camph., gr. ss.; pulv. Doveri, gr. v.; M. ft. chart, No. xvi. Cap. 1, q. 3 h. On the 7th, the second day after the operation, delirium subsided, and there being some tension of stump, the sutures were removed, and the edges of the wound brought together by adhesive plaster; the water dressings were continued. The stump commenced suppurating on the 9th, at the same time forming around the edges of the wound a greyish slough. Dressed with yeast poultice; pulse 98, and weak. Ordered eight oz. brandy, one bottle porter per diem, and beef tea ad libitum. 10th.—Was again so violently delirious last night that confinement of limbs was rendered necessary. Hypodermic injection of ten drops Mag. sol. morph. again given. Stump suppurating moderately; dressed with adhesive plaster and bandages. 12th.—Delirium continues, although he has sane intervals. Stump doing well; continue brandy and porter, with one gr. camphor, one gr. opium in pill, every hour, until sleep is secured. Pulse 96, and weak; surface pleasant, tongue dry. 14th.—Delirium continues, though at longer intervals; worse at night. Continue camphor and opium according to circumstances. 16th.—Patient had a good night's sleep, and anodynes were accordingly diminished to fifteen drops Mag. sol. at night. Stump was doing well, and presented the aspect of healthy ulcer. Dressed with ung. and bal. Peru, and strapped. Patient continued to do well until Oct. 10th, except when a small abscess formed in stump. This, however, was of short duration; and on the 9th of November he was discharged cured, the surface of the stump having entirely healed.

CASE III.—Compound Fracture of Knee-joint—Railroad Injury—Amputation of Thigh.—Henry Maynard, aged 16, native of N. Y., telegraph operator, was admitted during the service of Dr. Buck, at 10 o'clock, the night of Sept. 26, 1861, having, five hours previously, sustained a compound fracture of the thigh in the following manner:—While attempting to pass from one car to another, while the train was in motion, he slipped and fell, the hind wheel of the car passing across the lower part of the right thigh, close to the knee-joint. The wound thereby caused was six inches in length, extending from a point about three inches above the external condyle of the right femur, obliquely upwards and backwards, disclosing the existence of a comminuted fracture of the lower end of the bone communicating with the joint. The surrounding soft parts were very much contused and lacerated. At the time of admission, patient not suffering much from shock, the pulse being 90, and rather weak.

Dr. Buck was immediately sent for, and arriving at 1 A.M., decided upon the necessity of an amputation, and, as the patient was in a good condition, resolved to perform the operation at once. Ether was administered, and the thigh was amputated at the junction of the middle and upper thirds; the double-flap operation being practised. The hemorrhage was quite considerable, requiring the use of a number of ligatures. The flaps were brought together and kept in position by three acupressure needles, while the edges were approximated by sutures and plaster. Cold water dressings were then applied. During the operation, patient's pulse fell off somewhat, requiring the free use of brandy.

The day following the operation, the patient became quite delirious, and continued in that condition for three days. The stump, during this time, appeared quite tense, requiring the employment of irrigation. On the 29th, the two lower sutures were removed, and also one acupressure needle, which allowed the stump to discharge freely. On the 20th of October, all the remaining sutures and the needles were removed. The stump became very tender to the touch, and poultices were applied with a view of favoring suppuration and healing by second intention. The favorable progress of the case was interrupted by the appearance of bed sores on each side of the coccyx, which continued to claim attention for a fortnight or more, requiring the pretty free use of stimulants and nourishing diet to keep up the strength of the patient. At the end of that time, the stump took on a healthy reparative action, and the recovery was comparatively rapid.

The use of the infusion of green tea in the second case was, according to the statement of Dr. Roosa, attended with the best of results. The well known properties of this article would seem to indicate *a priori*, its special use in all cases attended with prostration of the nervous forces.

The general dressings of stumps, whether the operation be primary or secondary, are, for the most part, such as tend directly to the prevention of inflammation; for example, the application of the wet bandage and the use of irrigation. Very little attempt is made by the surgeons to secure union throughout the wound by first intention, the only desire being, by the use of sutures, adhesive plaster, and the like, to so approximate the cut surfaces as to lessen the space to be subsequently healed by granulation.

Dr. P. confirmed the statements in regard to the frequent occurrence of deafness after scarlatina, and read the following paragraphs from a Report of the New York Institution for the Deaf and Dumb for 1853, relating to this subject. After enumerating the diseases which have produced deafness, the writer says—

"Of the named diseases in our table, scarlet fever is by far the most frequent. One fifth of all the cases in our table are ascribed to that epidemic; and, as we shall hereafter show, a much larger proportion of the more recent cases. This disease and measles produce deafness by a continuation of the inflammation in the throat and fauces, into the ear through the Eustachian tubes. In some cases of deafness, caused by scarlet fever, suppuration takes place within the ear, the membrane separating the tympanum from the external passage is destroyed, and the small bones of the ear come away. After the infirmity is once established, there is seldom any rational hope of cure."

"A comparison of the European table of causes of deafness with that of America, shows that scarlatina is not as common a cause of deafness abroad as on this side of the Atlantic: there being only 128 out of 1,630 European cases assigned to it, or one in thirteen, whereas in the United States it is the cause in one case in five."

"We thus find that of the pupils admitted in the American schools before 1840, less than one in forty were deaf by scarlet fever; and of those admitted since 1840, more than one in eight lost their hearing by this disease. Compared with the whole number of cases of acquired deafness, those by scarlatina were one in seventeen before 1840, and not much less than one in three since 1840; or taking the western schools separately, we find, since 1840, 186 cases of scarlet fever out of 534, more than one third, in the former, and 76 out of 348, more than one fifth, in the latter.

"As a providential compensation for the increased activity of this epidemic, in destroying the sense most important to the intellectual and spiritual nature of man, it may be some consolation to anxious parents to reflect that there are of late, proportionally, fewer cases of the loss of hearing by other diseases than formerly.

"We have applied to some of the most eminent medical men of New York, for an explanation of the striking increase in the number of cases of scarlatina deafness since 1830. The answers of three of them, Prof. Joseph M. Smith, Prof. A. Clark, and Dr. A. C. Post, furnished statistical details that showed that, while this disease was rarely met with in this country, at least under a severe form after 1804 and before 1829, since that year it has assumed an epidemic form, and become one of the most fatal diseases of children. According to a table prepared by Prof. Smith, from the New York bills of mortality, the deaths by scarlatina in that city, during twenty-four years, from 1805 to 1828 inclusive, were only 97. In 1829, there were 188 deaths by that disease, and from that year to 1850, both inclusive, the total of deaths by scarlatina was 5,290.* During that period the proportion of deaths by this disease to the whole mortality, was more than one in forty; from 1829 to 1844, more than one in thirty. In Philadelphia, also, similar results are shown. There, the whole mortality from this disease, from 1815 to 1829, inclusive, was 92. In 1830 there were 40 deaths by this disease; in 1831, 200; from 1831 to 1846 inclusive, 3,391. A sudden and striking instance of mortality from scarlet fever, occurred in Boston about the same time as in New York and Philadelphia; and as the pupils embraced in our tables come from every part of the northern States, we cannot doubt that there has been a similar increase in the prevalence of this epidemic, at least over the northern half of the Union.

"Though this fact alone seems abundantly sufficient to explain the increase of cases of scarlatina deafness, other

* Since writing the foregoing, we have been indebted to Dr. A. Clark, of the College of Physicians and Surgeons, for a table, by which it appears that the deaths in this city, from scarlatina, from 1805 to 1828, 24 years, were 97, an annual average of 4; and from 1829 to 1852, also 24 years, they amounted to 6,730, an annual average of 290.

Reports of Societies.

OBSTETRICAL SECTION.

NEW YORK ACADEMY OF MEDICINE.
Stated Meetings, June and October, 1861.

ALFRED UNDERHILL, M.D., Chairman.
[Reported by M. G. PORTER, M.D., Secretary.]
DISCUSSION ON SCARLATINA (*continued*).

(Continued from page 858.)

DR. BULKLEY confirmed the statement that mild cases are oftener succeeded by sequelae. He invariably used warm baths as a protective against anasarca, and rarely saw it in his own practice. Among his remedies for anasarca were mustard and fomentations to the back for days successively, the vapor bath, etc. Mentioned slacking lime in a wet cloth as a convenient method of procuring the vapor bath.

DR. PORTER mentioned several malignant and fatal cases of scarlatina, which had come under his care during the past year, one dying in a convulsion within two hours of its seizure, and two others within two or three days. These were directly traceable to a fatal case which had occurred in the same house about a month previous. Several other children in the family, though constantly exposed, did not contract the disease. No means of prevention were used. Dr. P. also narrated a recent case of sudden death in the course of anasarca following scarlatina. The patient was a lad five years of age. The lower extremities and scrotum had been enormously swollen, but for two or three days preceding death, marked amendment had taken place, under the use of free doses of iodide of potash, and hopes of recovery had begun to be entertained, when sudden effusion probably occurred into the pericardium (manifested by a feeble and intermittent pulse), and the little fellow dropped off instantly while sitting up, talking cheerfully with the other children. A sister of this patient died a few days before from cerebral effusion as a sequel, and both had been mild cases of scarlatina.

reasons are suggested by Dr. Metcalfe, Professor Clark, and Dr. Reese. The first thinks that the type of scarlatina now prevailing, has a greater tendency than formerly to inflammation and ulceration of the throat and fauces, and thence into the ears;* the last suggests that the prevailing medical treatment of the disease is in fault. How far this last reason may be applicable, must be somewhat difficult to decide, when we reflect how small a proportion the cases of deafness caused by scarlatina, bear to the number of deaths by that disease.

"In New Jersey, in 1853, out of 5,615 deaths reported, 240 were by scarlatina. In Maryland, by the census of 1850, the deaths by this disease were 355, out of 6,984. Summing the two States together, we have 595 deaths by scarlatina, approaching the ratio of one in twenty of the whole mortality, and about one to forty births. We may, therefore, assume that in the middle States, one child on an average dies by scarlet fever, during the present epidemic cycle, out of every forty births.

"For several years past, the average of admissions of children deaf by scarlatina in the three north-eastern institutions, has been nearly twenty. The number of births in the New England and Middle States, judging by the numbers returned from New Jersey and Maryland, cannot be less than 240,000 annually. It appears, then, that only about one child in twelve thousand becomes deaf by scarlet fever, while one in forty dies of that disease. In other words, *the chances to every child of loss of life by scarlatina, are three hundred times as great as the chances of the loss of hearing.* It is evident from this statement, that a physician may attend several thousand cases of this disease, and witness several hundred deaths by it, without being able to decide positively, from his own experience, that one mode of treatment is more effectual than another, in preventing the distressing, but comparatively rare consequence of deafness.

"Dr. Smith thinks that the scarlatina epidemic which has prevailed in the United States for the last quarter of a century, has begun to abate; and that, at no remote period, this disease will appear as rarely in our bills of mortality as it did before 1829. Whether other diseases, now infrequent or unknown, will prevail as causes of the deafness, as well as death of children, as the scarlet fever ceases to prevail, is a question in the hands of Providence. The afflictions of the children of men may diminish, as the laws of life and health become better understood and obeyed; but the past history of our race affords no warrant for believing that they will wholly disappear, till some great change shall be wrought in the constitution of our planet and of its inhabitants.

"A glance at Table IX. will show that in Leipsic, Dresden, and Altenburg (or in other words, in Saxony and the adjoining Duchy of Saxe-Altenburg), scarlet fever is, or was a few years since, as prevalent as a cause of deafness, as it is in the United States. On the other hand, in Italy, France, Belgium, and Rhenish Prussia (Cologne), it seems as rare as it was in this country before 1830.

AMOUNT OF ARMY RATIONS PER MONTH.—The following figures show the amount of commissary stores which will be consumed in one month by the United States army when brought up to the standard authorized by Congress, viz. 500,000 men. It will be seen that the labors of the commissary department are anything but trivial, and that the cost of feeding an army is a somewhat serious item. 11,250,000 pounds of pork, or 18,750,000 pounds of fresh beef; 105,380 barrels of flour; 37,500 bushels of beans, or 1,500,000 pounds of rice; 1,500,000 pounds of coffee; 2,250,000 pounds of sugar; 150,000 gallons of vinegar; 225,000 pounds of candles; 600,000 pounds of soap; 6,384 bushels of salt; and 6,600,000 pounds of potatoes.

* Dr. Clark seems to concur in this opinion: observing that "some of the older physicians inform me that the disease was marked by great fatality in the last years of the last century; and that during all the period distinguished for its low mortality, the affection still prevailed, but of so mild a type as to demand little attention from the physician."

American Medical Times.

SATURDAY, DECEMBER 7, 1861.

THE AGE OF UTERINE DISEASE.

It has been remarked by a popular writer that this is "the age of uterine disease." In the medical profession, and with the other sex, the assertion certainly is not wide of the truth. Utterine diseases have been the all-engrossing theme of a large class of practitioners for many years. Volumes have been written upon these affections, with chaste or unchaste illustrations of every grade, from the secret and undetermined forms of sterility, to the gravest forms of cancer; interminable discussions have been held upon the ever-varying phases of the diseases of this organ; and students of uterine pathology have always been rewarded with rich discoveries in this fecund placet. If we were to believe all that is written of the inherent and acquired diseases of the organ, on the integrity of which depends the perpetuation of our species, how surely fated to early extinction would seem the human race? If it be perpetuated, it would be through decaying germs that must give origin to imperfect forms and decrepid generations.

But while it is true that uterine diseases exist and form a large class of affections which are capable of destroying the health and happiness of the sex, can any observant practitioner doubt that the uterus is, in our time, the scapegoat of many a latent malady of the female that is not correctly diagnosticated? Said an eminent obstetrician of this city: "If I should confirm the diagnosis in every case that is sent to me from the country, as one of undoubted uterine disease, I could add thousands of dollars to my annual income." He was emphatic in the expression of his opinion, that medical men, nowadays, conveniently referred to the womb a vast number of affections of which they either had not the tact or knowledge to determine the seat and nature. He examined the consulting patient with an habitual anticipation of finding a normal condition. Such statements are startling, and indicate a vast amount of carelessness or ignorance, or both, in the medical profession. In general, no diseases are more readily susceptible of accurate diagnosis than those peculiar to the uterus. They belong, in fact, to the diseases distinguished by the French as External Pathology. If there is an ulcer on the parts it is seen as distinctly as if on the leg; if there is unnatural enlargement, it is as detectible as a swollen finger; if there is a tumor of any kind or description, it is as demonstrable as a similar growth on the face; if there is displacement in any direction, it is as apparent as a dislocated limb. Indeed, a physician, with all the mechanical aids which we now possess for investigating uterine diseases, cannot be held guiltless of culpable ignorance who pronounces falsely upon the presence of grave lesions. He has no excuse for diagnostinating an ulcer when there is none; or prolapsus, when the organ is in a normal position; or anteflexion or retroflexion, when neither exists. And yet these false opinions are, it must be admitted, daily given, greatly to the discredit of many a physician in the eyes of an honest and competent expert.

We believe that these errors are generally the result of carelessness. There is in many, also, a disposition to give always a definite opinion, especially in an obscure case; and it is convenient to fix upon an organ which has the popular acknowledgment of being the happy abode of all the undiscovered maladies of the female organization. The uterus has now come to enjoy the relative position of the liver in its ability of concentrating within itself all the undefinable diseases to which the sex are subject. Although the term "liver complaint" has now become obsolete in the nomenclature of many practitioners, yet its place is more than supplied by the phrase "uterine disease."

Aside from the humiliation of professional character which results from such ignorance and carelessness, there are other evils of a very different kind that must not be overlooked. We have thereby opened a large and fertile field for the special advantage of quackery in its lowest and most revolting forms. It is not strange that the interesting and interested subjects of these affections have become alarmed at the almost universal prevalence of the belief in the disabilities peculiar to their unfortunate sex. Thousands of nervous ladies suffering from some slight and obscure derangements of digestion, or other departure from health, are secretly informed by friends that the womb, that mysterious organ, with its innumerable susceptibilities, is liable to an infinite number of strange disorders. At once a mania for an investigation seizes the individual victim, which nothing but the manipulations with the speculum can relieve. And alas! too often instead of relieving a proper apprehension on the part of the patient, even though she is correctly informed that the womb is not diseased, a new source of excitement is established which is far more dangerous to her happiness than actual disease. If her ailments are lightly treated by her medical attendant she readily falls into the hands of a vulgar irregular, and becomes the dupe of his villainous machinations. In more than one instance has the profession of this city witnessed a uterine furor, created by an unblushing quack, which neither reason nor modesty could control. And but recently we noticed an instance in which a most ignorant pretender opened a hospital for the treatment of uterine tumors, in one of the most intelligent and moral communities of an interior state; crowds of women flocked to him, and all were found to be suffering from tumors of the womb. By accident a patient more intelligent than others, discovered that the tumor was a piece of raw meat, which was introduced at the first examination, and which, after long treatment, was removed to the great relief of the patient.

It is time that uterine pathology was thoroughly understood by every practitioner. It is not, as we have already intimated, difficult to learn so thoroughly that mistakes in diagnosis will be only exceptions, and not, as now, the rule.

THE WEEK.

THE annual meeting of the Association for the Relief of Widows and Orphans of Medical Men in this city, was held in the lecture-room of the Academy of Medicine, corner of Twenty-third street and Fourth avenue, on Wednesday afternoon, Dr. ANDERSON, President of the Society, in the chair, and Dr. J. W. G. CLEMENTS, Secretary. The meeting was for the election of officers, and resulted in the choice of the present incumbents. The Society has been in existence nearly twenty years, and, as will be seen by the subjoined

statement, has accumulated a handsome property. The fund has been but lightly drawn upon as yet, there being only two annuitants. The roll of members includes all the more illustrious names of the profession:

"President, JAMES ANDERSON, M.D.; Vice-Presidents, G. P. CAMMANN, M.D., H. D. BULKLEY, M.D., WILLIAM DETMOLD, M.D.; Secretary, J. W. G. CLEMENTS, M.D.; Treasurer, EDWARD L. BEADLE, M.D.; Managers, JACOB HARSEN, ISAAC E. TAYLOR, JOHN R. VAN KLEEK, S. P. WHITE, JAMES R. WOOD, J. O. STONE, and S. CONANT FOSTER."

It has always been customary for the Association to have an annual dinner, but last year and this the festivities have been omitted, in consequence of the state of the country. The Secretary presented the following annual statement of the condition of the Society:—

"All the funds of the Society, as shown by the last Annual Report, in September, 1861, were invested. They amounted to \$31,500, bearing interest at seven per cent, leaving a balance due the Treasurer of \$26 11. The receipts for the year ending September, 1861, were \$2,606 87; disbursed for same period, \$341 53. The members of the Society now number one hundred and nine, of whom seventy-one are for life, and thirty-nine annual subscribers; besides, the benefactors number twenty-seven, of whom five are laymen. The Society extends its aid to the families of three of its deceased members. Applications for membership will be received at the general meeting in November. Annual members pay an initiation fee of \$10, and \$10 dues in semi-annual payments; or \$100 paid at one time constitutes a member for life."

We would call attention to the paper on Plaster of Paris Splints, by Dr. LITTLE, in another part of this number, as one of rare interest to the practical surgeon. The apparatus described is exceedingly simple, easy of application, and the results following its use, as illustrated in the cases detailed, are sufficiently good to recommend it as a valuable substitute for the ordinary splints. The advantages claimed for the new mode of treatment are considerable enough to invite a trial from all those who are in the habit of meeting with fractured bones.

We notice the discontinuance of the *BERKSHIRE MEDICAL JOURNAL*, which has just completed a single year of publication by the issue of the November and December numbers under one cover. This journal has maintained a most creditable position in our current medical literature, and we announce its failure with much regret. To the editors, PROFESSORS THAYER and STILES, the profession of Western Massachusetts, at least, are under great obligations for their effort to establish a medium of communication of the proceedings of their societies.

We have suggested the importance of a preliminary examination of medical students as to their educational qualifications for the study of medicine. This course is now the rule established in England. It is an interesting fact that the earlier medical men of this country endeavored to enforce similar provisions. In an interesting historical sketch of "The Medical Association of the County of Berkshire," Mass. (*Berkshire Medical Journal*), we find the following Rule was adopted as early as 1794:—"No member shall take a pupil and put him to the study of physic until he have a good knowledge of Mathematicks and the English language, and can construe and parse the Latin language with accuracy."

It is our melancholy duty to record the death of one of our most worthy city physicians, RICHARD S. KISSAM, M.D. He died at his residence in Great Jones street, on Thursday, the 27th inst., of pneumonia, in the fifty-third year of his age. We shall present a more extended notice of the deceased in a future number.

In another column is a communication from a "Country Surgeon," urging the employment of surgeons by the managers of railroads. The subject is one of great importance to the welfare of the travelling public, and the arguments brought forward are perfectly conclusive. We trust this matter will not be allowed to rest here, but that the intelligent writer of that paper will take steps to unite the efforts of other physicians living on the line of railroads, to bring the subject before the Boards of Managers. The plan proposed must commend itself to every practical and humane mind.

How can the County Medical Societies be made more active? The following answer is given by the Berkshire (Mass.) *Medical Journal*, in a review of the Berkshire County Medical Society:—

"All experience tells us that Societies which meet monthly are much better attended than those which only assemble semi-annually or at longer intervals—the interest will not survive the long intermission. Another prominent cause of the increased success after the vote to have monthly meetings, is to be found in a proposition of Dr. Collins, which is in the record of the very next meeting, in the following words: 'Remarks from Dr. Collins relative to the manner of conducting our meetings; asking for more method, and suggesting that the President make an *individual* call upon the members to relate anything of interest which has occurred in the practice of each since the last meeting, and that ten minutes be allowed each member for such recital.' The proposition was adopted, and has since become the regular order of business, with the effect of bringing out much matter that would have been lost, as is always the case, from the diffidence of members and from want of system. The records, which formerly contained merely the votes of the Society—of censure on delinquents, the management of the finances, and tributes to the memory of the dead, have grown, since a regular order of business was adopted, more and more valuable in a scientific point of view."

doctor, who, when he arrives, is perhaps no surgeon, is scared at the aspect of the bleeding, mutilated object before him, or has no appliances suitable to the case, and the sufferer is bundled up in the best manner possible, put into a freight car, and sent to a hospital many miles away, there to die from the exhaustion of the journey superadded to the original shock; a valuable life, if only to his family, being thus perhaps unnecessarily lost.

I proceed to illustrate my subject by one or two actual cases. In October, 1857, a boy jumped out of the baggage car of an express train, at full speed, against the rocks in a cutting, and rebounding on the track was picked up horribly mangled. His injuries were as follows:—the left leg from midway below knee and foot completely smashed and in part torn away, fracture of the left thigh, compound fracture of right leg about midway below knee, both bones protruding, compound fracture of right great toe, and a severe scalp wound about three inches in length. He was quickly removed to his parents' residence and medical assistance was promptly at hand. I had the satisfaction of discharging him sound, of course with loss of one leg below the knee, after four months' attendance, for which I may observe *en passant* that, as in other minor cases, I received no compensation whatever. I do not think there can be a doubt that, had this boy been far from home, and been jolted along for many miles, however carefully, to a distant hospital, he would have been added to the list of railway victims, and his death regarded as a matter of course.

Some two years since, a train ran into another stationary on the line, injuring several persons, among them a lady, who was jammed in such a manner as to tear the abdomen. The shock to the system was very severe. After some delay, she was put into a car, although the accident happened near an important town, carried eight or nine miles, then from the station to a hotel, where within an hour or two she died. On the inquest, the medical attendant testified that she had not sustained any serious internal injury, and attributed her death mainly to the shock of the accident. In this case the shock to the system could hardly have been greater than in the preceding case, and the actual injuries were certainly far less severe. Now, had the sufferer been removed gently to the nearest town, or flag station, her wound dressed, and means promptly taken to allay her system, instead of time being lost, and carrying her about from place to place in her agony, a downward impetus being thereby given to already depressed and rapidly failing vital powers, might not the result have been different, and not only a valued life saved, but liability on the part of the company to the highest amount of individual damages avoided?

This is a matter in which not only the public and life insurance companies, but also the railroad companies themselves, apart from higher considerations, are interested even as a matter of economy. As regards the latter, are they not besides often mulcted in heavy damages for almost imaginary, or at least greatly overstated, injuries, for want of competent medical testimony on their side based on actual examination at the time of the accident? So much for the evil to be remedied. Now for the remedy itself.

Let the companies, where practicable, appoint district surgeons, unsalaried, but payable for actual services, at the principal towns along the line, and not exceeding from ten to fifteen miles apart, the district of each to extend to the flag station nearest to midway between any two. The advantage attending such regular appointments would be, that where medical assistance was not immediately at hand, the employees would know exactly where to send. At each such surgical station a small room should be set apart on the ground floor, furnished with an iron cot bedstead and bedding, a stretcher, a small table, one or two common chairs, and a small wood stove, by which the room could be heated in a few minutes if required in winter, or hot water, or a brick for application to the feet at any time. I may here observe, that if the companies did their part, I

Correspondence.

EMPLOYMENT OF SURGEONS TO RAILROADS.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—Living in the vicinity of a great railroad, and having on several occasions been called to attend severe injuries occurring thereon, it has been a matter of wonder to me, that companies have never adopted, nor the public called for, more efficient arrangements for the saving of life in the casualties that every now and then happen. These are frequently of the most appalling character, and occur often in the most out-of-the-way places, so that before medical assistance can be obtained much time is necessarily lost. But ought we not to reduce it to a minimum? We know there is not a day that some terrible accident may not happen; that many die from shock and long exposure; and that the management of the injured, during the first few hours, often determines the question of life and death; yet, that no local arrangements are made to meet such emergencies. A man is hurt on the line, people run for the nearest

have no doubt each surgeon could raise, among his own friends and patients, enough not only to furnish the main station, but also to provide every flag station with a stretcher and mattress to be kept always ready, and of which the whole first cost would probably not exceed fifty dollars. The surgeon might also keep at the station a little linen, lint, bandages, sponges, a few splints, and such minor articles for immediate use. In case of an accident, a stretcher could be obtained from the nearest flag station, or those from the adjoining ones, if several were seriously hurt, and the medical officer summoned, also those of adjoining stations if necessary. This would not preclude, however, the employment of any medical assistant immediately available. If the injury were too severe to risk removal, the patient could be carried to the nearest flag station until the first danger had subsided; when practicable, however, he should be carried to the nearest district station, his immediate wants there attended to, and provision made for safe removal. When a surgeon is summoned to the scene of an accident he should have the right to avail himself of any passing train, that as little time as possible might be lost, and it should be his duty to examine carefully into the amount of injuries sustained, and to keep notes of the same for the future refreshment of his memory; also, to furnish a copy to the superintendent to be kept on file at the chief office. In cases of fraudulent or exaggerated claims upon companies, the medical officers would become their most important witnesses, and I believe the amount thus saved would far exceed all costs, and tend greatly to diminish litigation.

Among the advantages arising from the appointment of regular medical officers not the least would be, that many practical and intelligent minds would be devoted especially to the subject under consideration, and suggestions at once simple and valuable would gradually become embodied into rules and regulations for the guidance of employees in emergencies, tending materially to alleviate human suffering and save lives, which would no longer be allowed to ebb away on the hard floor of a baggage room amid a crowd of curious bystanders, nor would the usefulness of a medical man be crippled for want of the most necessary conveniences. In a word, system would take the place of chance arrangements with all their attendant confusion and increased risk.

With some such plan as that here crudely and briefly sketched out, how many lives, now annually sacrificed on the thousands of miles of railway, might be saved! A system would be by degrees introduced, simple in detail, inexpensive in its working, efficient in its results. The travelling public would find in it an additional guarantee for their safety; the tax now often devolving upon medical practitioners would fall on the shoulders of the companies, which, however, would gain far more than they would lose by the change; and the general interests of humanity would be served.

In conclusion, I believe that the man of means and influence, who would grapple with this subject, and devote his energies to arousing the public and life insurance companies, railroad directors and legislatures to the matter, would as much entitle himself to be regarded as a public benefactor as the founder of the Royal Humane Society.

Yours, &c.,
A COUNTRY SURGEON.

NOTE TO DR. ROGERS'S PAPER ON REDUCTION OF DISLOCATIONS AT SHOULDER-JOINT.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—In reading over my paper on Dr. N. R. Smith's method of reduction of the dislocation of the shoulder-joint, I discover the omission of a note I had prepared, to account for my silence respecting the long head of the *triceps*, while upon the subject of the muscle connecting the scapula and the forearm—the biceps. By accident it

got out of place, and I have only now found it by looking among my papers. It accompanies this, and even at this late date you will do an act of justice both to the subject and to myself, by giving it a conspicuous place in the pages of your journal.

Yours, &c.

S. ROGERS, M.D.

NEW YORK, Nov. 28th, 1861.

"Anatomically, and physiologically, the long head of the triceps belongs to this class, but surgically, it is a muscle of little importance in this dislocation, from the fact that in the common dislocation into the axilla, the head of the bone passes entirely forward of it, and consequently in either of the usual modes of reduction discussed in my paper, does not come in contact with it, and of course does not in any way oppose reduction; or at least does not mechanically. As in either manipulation it is completely relaxed, it cannot be supposed to afford any physiological obstacle. In the rare dislocation, backwards into the infraspinatus fossa, the head of the bone passes above it. By anatomists it is stated to protect the head of the bone from downward and backward dislocation, but I must confess my inability to see, that as an articular muscle, it is of much importance. To me it appears to have particular value as a part of the extensor muscle of the forearm, in consequence of its longer fibres and greater range of action than the two other portions of this muscle. In the manipulation advocated in this paper, the portion of the triceps in question is perfectly relaxed, and therefore, opposes no movement whatever."

RECLAMATION.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—Permit me to correct a misstatement through inadvertence or forgetfulness, in the inaugural address of my friend, Professor McCready, at the opening of the Bellevue Hospital Medical College. The learned professor, in the course of his remarks, takes occasion to say:—"Something more than twenty-five years ago, I was a student of medicine in this our goodly city of New York. * * * Clinical teaching—I am speaking of medicine,—there was none, at least none worthy of the name. On the performance of a capital operation, the theatre of the New York Hospital would be well filled with students and doctors, and occasionally during the winter, some half dozen students would be galvanized to attend the physician on duty in his visits to the wards; but the attendance evidently soon became equally tedious to the professor and the students, and in a week or two was sure to terminate."

Now, with all becoming deference, I beg leave to dissent from this statement. At the New York Hospital since the time of Dr. David Hosack until the present hour, the importance of clinical instruction has been fully insisted on, and there has always been *clinical teaching*, in its appropriate place (at the bedside), with occasional clinical lectures. Within my recollection (since 1826), a series of clinical lectures were delivered in the Hospital Theatre by the late Dr. John Watts, President of the College of Physicians and Surgeons. Dr. A. H. Stevens was in the habit of delivering several lectures in the course of his attendance, every season; many of these have been published in pamphlet form, and in the medical journals. The visits of Dr. Mott were attended by a large number of students, and it was his constant practice to remark fully upon all cases presenting any points of interest. The same remark will apply to the visitations of Drs. Thos. Cook, Sr., J. Kearney Rodgers, and Jos. M. Smith. At a later date, in 1842, Dr. J. A. Swett delivered at the New York Hospital the first course of lectures on diseases of the chest, and in subsequent years he continued to lecture down to the period of his decease. Drs. John Watson and H. D. Bulkley have also delivered frequent courses of lectures, and with great acceptance; but these were established under the *new régime*, and since the

period alluded to by the Professor. I only wish to claim that "something more than twenty-five years ago," there was "clinical teaching worthy of the name," in this our goodly city of New York.

Yours, &c.,

J. G. A.

NEW INSTRUMENTS FOR TRACHEOTOMY.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—In the course of a series of experiments on respiration, performed some time since, I had occasion very frequently to perform tracheotomy on animals, and being generally without an assistant, experienced much delay and embarrassment from the extreme caution necessary to prevent troublesome hemorrhage. This led me to seek for some instrument for the division of the tissues between the skin and the trachea, which should be safer than a knife, and more expeditious and certain than the fingers or the handle of the scalpel. Accordingly I had two instruments made, resembling the hook used in the operation for strabismus, but stronger and somewhat more pointed at the extremity. Taking one of these in each hand, and operating something as one would with dissecting needles, I was enabled to divide one layer of tissue after another with the utmost safety and despatch. The points of the instrument were so blunt as to render it almost impossible to penetrate the coats of a vessel, and hence the ability to hemorrhage, which constitutes the chief danger in this operation, was avoided. Indeed, I have often opened the trachea almost without shedding a drop of blood, except that from the skin and from the trachea itself. In an operation recently performed upon a child by the aid of these instruments, I did not find it necessary to employ a sponge during the whole operation.

In my experiments upon animals, I found that this manner of dividing the tissues did not prevent their union by first intention. It appears to me that these instruments might be useful, not only in tracheotomy, but in all operations where it is necessary to expose important vessels or nerves, as in ligating arteries, cutting down upon bullets in the neighborhood of large vessels, etc.

Yours, &c.

A. H. SMITH. M.D.

BRISTOL, PENN., Dec., 1861.

THE CASE OF DR. HASBROUCK.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—I notice in your Journal of the 23d an extract from a letter published in the "*London Standard*," describing a visit to the Lunatic Asylum on Blackwell's Island, in which allusion is made to Dr. F. Hasbrouck, late of this village, in the following terms:—"**** He left medical life, and started a paper at Fishkill (Peekskill). A few months ago the mob went to his office, and dragged him out on account of a secession article that had appeared in the columns of his paper. The effect has been terrible. He is a hopeless maniac, but harmless," etc. Now the facts of the case are as follows:—Dr. H., after leaving New York, practised his profession for some years in Sing Sing, where he was physician to the State Prison; he afterwards removed to Tarrytown, where he failed in acquiring much professional business. Some three years since he removed to this village and assumed the editorship of an old democratic paper, in connexion with the practice of medicine. He totally failed, however, in gaining the confidence of the community as a physician. His strong and unreasonable political prejudices, excitability, lack of judgment and foresight, with other disqualifying traits, soon satisfied the readers of his paper that he could not succeed in his editorial capacity, as the result proved. More than a year ago his friends believed him totally insane, and predicted that unless he abandoned politics he would eventually become wholly so. Among his eccentricities may be mentioned

his nomination of Sam Houston for the Presidency, offering himself as a stump candidate for Congress, sustaining the Southern Confederacy, etc., etc. To the writer Dr. H. often avowed his belief that he should die of cerebral disease, as he suffered greatly at times from pain in the head, owing to a severe fall on the ice, when about sixteen years of age, striking on the back of the head with great violence. It is also stated on good authority that he had formerly suffered from insanity when residing at Sing Sing, and that it is hereditary in the family. There is no truth whatever in the statement that he was dragged from his office, etc. This probably grew out of the fact that at a Republican flag-raising he was called on for a speech, and told by several of those assembled that he must retract some secession statements he had made, and pledge himself to sustain the Union cause. Soon after this he became furiously insane, but his family and most intimate friends had been daily expecting it for weeks if not for months previously, and in fact had excused his acts, as well as editorials, on the ground that his mind was not wholly sound. During all this time he had been jealous and suspicious of his best friends, wholly insensible to advice, wrong-headed, perverse, irascible, and implacable—in short, his insanity came on gradually, as it usually does, and was marked by the usual phenomena, except that it was complicated with violent epileptic convulsions, continuing for hours—a disease, moreover, from which he had formerly suffered. These statements are made in justice to the citizens of this village, who, notwithstanding the fact that the paper, conducted by Dr. H. and now by Dr. H. Sr., has been indicted by the Grand Jury of the county for its treasonable character, have peaceably tolerated its secession articles, and neither threatened nor inflicted any violence upon its conductors.

Yours, &c.,

JUSTICE.

PEEKSKILL, Nov. 28, 1861.

Army Medical Intelligence.

SURGEONS OF THE SECOND NAVAL EXPEDITION.—Medical Director, Dr. W. H. Church, of New York. 51st Reg., N. Y. Vols., Surg., Dr. E. W. Buck; Assist. Surg., Dr. C. W. Torrey. 53rd Reg., N. Y. Vols., Surg., Dr. H. J. Phillips; Assist. Surg., Dr. Dubreuil. 23rd Reg., Mass. Vols., Surg., Dr. Geo. Derby; Assist. Surg., Dr. Silas E. Stone. 24th Reg., Mass. Vols., Surg., Dr. Sam. A. Green; Assist. Surg., Dr. Hall Curtis. 25th Reg., Mass. Vols., Surg., Dr. J. Marcus Rice; Assist. Surg., Dr. Theron Temple. 27th Reg., Mass. Vols., Surg., Dr. Geo. A. Otis; Assist. Surg., Dr. Samuel Camp. 5th Reg., Ct. Vols., Surg., Dr. De Witt C. Lathrop; Assist. Surg., Dr. J. V. Harrington. 10th Reg., Ct. Vols., Surg., Dr. A. T. Douglas; Assist. Surg., Dr. M. F. Newton. 50th Reg., Penn. Vols., Surg., Dr. Livergood; Assist. Surg., Dr. Noble.

Dr. John McNulty, formerly Surgeon to 37th N. Y. Vols., has been appointed Brigade Surgeon on the staff of Major General Dix, at Baltimore, and Dr. Wm. O'Meagher has been appointed Surgeon in his stead.

VENEREAL IN THE ARMY.—SUGGESTIONS AS TO ITS REMOVAL.

[Army Correspondence of the AMERICAN MEDICAL TIMES.]

THE SANITARY COMMISSION, which extends a sort of general survey over the sanitary regulations of the entire army, seems to have overlooked one very fruitful source of disease, which is not beyond their power to remedy. Not a day passes in the service of any regiment in which at least five men thereof are not unfit for duty from gonorrhœa or some form of venereal disease or their effects, and as the army remains stationary the mischief seems to be on the increase. When we multiply this number by the number of regiments in the field, the detriment to the public service assumes such magnitude as to justify the military in adopting the most stringent measures for suppressing the source of this mischief. Houses of prostitution spring up, and

multiply in every village, town, and city contiguous to encampments, and Washington especially is at present stocked with the pestilential dregs of northern cities, from which we may expect during winter more havoc to the health of our soldiers than from fever or any other disease. We are aware that the moral sensibilities of the country do not allow the salutary regulations adopted by European governments to be applied to the class of women who follow the degraded life of prostitution, but the public weal at present requires that the health of the army should not be sacrificed to misguided sensibility, and demands either that the diseased prostitutes should be confined in an asylum where they can inflict no public loss, or that the houses of prostitution should be rigorously closed, and their inmates subjected to the most rigid police surveillance. The surgeons in camp, who witness daily the effects of this evil, have no means of correcting it, or of drawing the attention of the military authorities in Washington to it. The sanitary commission, to whom so much has been intrusted in regard to health regulations of the army, and whose province it is, if they have any, to suggest to the heads of the military department whatever tends to secure the health of the troops, might very properly include some regulation regarding this evil and its source among their recommendations. We think they would, by bringing military authority to check this evil, confer a greater benefit on the army than any they may lay claim to from their suggestions regarding ventilation, cleanliness, sinks, the antidiol effects of quinine, and many other of the like, which perhaps were as fully appreciated before as after they were promulgated with their sanction.

Yours, &c.

FIELD SURGEON.

NAVY SPLINTS.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—The splints furnished by the Navy Department are models of simplicity, utility, and economy. They can be easily made by the ship's carpenter at sea, under the direction of the medical officer.

The set of splints consists of a double inclined plane; a long splint for fractures of the lower extremities, with a belt and perineal pad and strap; a short carved splint for the inside of the thigh; two carved splints for general use (all of which have pads fitted and tied on them); a set of leathered wooden splints, two sheets of cotton wadding, and a package of tow. The double inclined plane has the lower part so arranged as to be easily detached, and used as a fracture-box when required. It is also provided with large buttons on the bottom, which, when turned crosswise, make the apparatus sit more firmly on the mattress.

The long splint for the lower extremities is adapted for the use of an adhesive plaster extending band. A strip of adhesive plaster about two inches wide is applied to the limb, in the direction of its axis, from near the seat of fracture, down one side and up the other, leaving a loop or stirrup under the sole of the foot. The whole is then enveloped with a roller bandage, applied with a moderate degree of firmness. A thin piece of board, about two inches square, is made to adhere to the inside of the loop or stirrup at the sole of the foot, and around this, and over the hook of the splint, a piece of tape is passed, by which to make extension.

A pocket is made in the belt to receive the upper end of the splint; and the buckles on the outside of the pocket receive the ends of the perineal straps for counter-extension.

To adapt the splint's to opposite sides it is only necessary to take out the hook, and adjust it so that the opening looks upwards.

Yours, &c.,

W. K. SCOFFIELD, M.D., U.S.N.

FEVERS AT FORTRESS MONROE.—An intelligent surgeon writes: The fevers here are the most refractory I have ever witnessed, resisting the best remedial agents. Quinine is wholly ineffectual in all its stages, but is still to be commended as a prophylactic and tonic substance. Emesis, the more powerful the better, I have learned to be the only reliable treatment in the initial stage of typhoid. Even if nothing else is done, this will suffice to place the disease under what we may term "control," and without it you may as well confess yourself, at a very early point in its progress, vanquished.

THE NUMBER OF CANDIDATES that have applied to the Medical Examining Board of the State of New York is 431, of which 203 passed as Surgeons, 155 as Assistant Surgeons, and 69 were rejected. The Board consists of Drs. Hun, March, and Cogswell, of Albany.

NAVAL MEDICAL BOARD.—The Naval Medical Board, composed of Surgeons John A. Lockwood, Charles H. Wheelwright, and John Y. Taylor, continues its sessions at the Naval Hospital, Brooklyn. Forty-eight candidates have been reported qualified since the 1st of August. Ten more are required to fill existing vacancies. Qualified medical men under twenty-six years of age, wishing to enter the navy, should apply to the Hon. Gideon Welles, Secretary of the Navy, for permission to appear before the Board for examination, stating age, place of birth, and actual residence, accompanying their request with testimonials of moral character. The following gentlemen have been found qualified since the last publication:—Thomas N. Penrose, Penn.; Samuel W. Abbott, Mass.; Edward C. Ver Meulin, N. J.; Thomas Hiland, N. H.; Newton H. Adams, N. Y.; George D. Slocum, N. Y.

Medical News.

GRADUATES AT THE BERKSHIRE MEDICAL COLLEGE.—The following gentlemen received the degree of doctor of medicine at the Berkshire Medical College, at the close of the session of 1861, after examination: David DeLos Bowen, John Thomas Benham, David Foss, George Washington Gale, Jr., Lucius Barstow Irish, Robert Hazard Morey, Louis Edwin Norris, Nathaniel Morton Ransom, Samuel Kenrick Rich, Myron Winslow Robinson, Frank Augustus Sabin, Joel Stevens, Charles Elliot Streeter, Augustus Van Cleef, and Nathan Hand Wright; and Robert William Gray, M.D. Dowdoin, *ad eundem*. We are too early in press for further particulars.—*Berkshire Med. Jour.*

QUESTIONS IN ANATOMY.—Professor Ford has prepared for his classes series of anatomical questions, of which we have received the first fasciculus, containing more than 500 questions on osteology. They are very full, as may be supposed from their number, and cover the structure and relations of all the bones; and as there are no answers printed with them, they form a very valuable catechism.—*Berkshire Med. Jour.*

DEATH OF GEOFFROY ST. HILAIRE.—This great naturalist died on the 10th Nov., at the age of fifty-six. Isidore Geoffroy St. Hilaire was a member of the Academy of Sciences, Honorary Inspector-General of Public Instruction, Professor at the Museum of Natural History, Professor of Zoology at the Faculty of Sciences, and member of the Academy of Medicine. By his exertions the zoological gardens, lately established at the Bois de Boulogne, were founded. The deceased *savant* was the son of Etienne Geoffroy St. Hilaire, whose fame he has worthily continued; he was born at Paris, at the Jardin des Plants, on the 16th of December, 1805.—*Lancet*.

TO CORRESPONDENTS.

Dr. O'Meagher.—(Surg. 37th Reg., N. Y. Vol.) Paper received and will appear soon.

Query.—What provision is made by Government for the families of army or naval surgeons in view of the accidents of war or shipwreck?

S. R. P.—Next week.

S. R.—Unavoidably delayed till next number.

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK,

From the 25th day of November to the 2d day of December, 1861.

Abstract of the Official Report.

Deaths.—Men, 60; women, 81; boys, 101; girls, 81—total, 382. Adults, 150; children, 182; males, 170; females, 162; colored, 1. Infants under two years of age, 110. Children reported of native parents, 22; foreign, 126.

Among the causes of death we notice:—Apoplexy, 5; Infantile convulsions, 15; croup, 9; diphtheria, 10; scarlet fever, 23; typhus and typhoid fevers, 8; cholera infantum, 0; cholera morbus, 0; consumption, 51; small-pox, 5; dropsy of head, 12; infantile marasmus, 20; diarrhoea and dysentery, 6; inflammation of brain, 7; of bowels, 13; of lungs, 22; bronchitis, 18; congestion of brain, 7; of lungs, 0; erysipelas, 2; whooping cough, 4; measles, 2. 175 deaths occurred from acute disease, and 29 from violent causes. 213 were native, and 119 foreign; of whom 74 came from Ireland; 8 died in the Immigrant Institution, and 41 in the City Charities; of whom 18 were in the Bellevue Hospital.

Abstract of the Atmospheric Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

1861	Barometer.		Temperature		Difference of dry and wet bulb. Thrh.		Wind.	Mean amount of cloud.	Humidity Saturation, 1000
	Mean height.	Daily range.	Mean	Min.	Max.	Mean			
	IN.	IN.	*	*	*	*			
24th.	29.67	21	28	81	45	6	8	W.	661
25th.	29.68	.07	35	81	40	6	8	W.	651
26th.	29.99	24	34	28	40	6	10	W.	624
27th.	30.04	11	37	29	48	5	8	W. to S.	699
28th.	30.01	.14	40	36	45	5	9	S. W.	5707
29th.	29.63	.40	44	38	50	2	3	NE. to SE.	851
30th.	29.70	.21	40	35	45	5	9	NE. to NW.	5
									707

REMARKS.—24th, Variable P.M., snow late at night. 25th, Snow early A.M., day variable, wind fresh. 26th, Sky variable at mid-day. 27th, Cloudy P.M., with very light rain. 28th, Light fog early A.M., very light rain eve. 29th, Fog A.M., light rain during the day. 30th, Storm early A.M., with rain and snow, clear P.M. Amount of rain, 1 inch.

MEDICAL DIARY OF THE WEEK.

Monday, Dec. 9.	{ NEW YORK HOSPITAL, Dr. Peters, half-past 1 P.M. BELLVEUE HOSPITAL, Dr. Clark, Is. Hos., half-past 1 P.M.
Tuesday, Dec. 10.	{ NEW YORK HOSPITAL, Dr. Watson, half-past 1 P.M. BELLVEUE HOSPITAL, Dr. Loomis, half-past 1 P.M. OPHTHALMIC HOSPITAL, 1 P.M.
Wednesday, Dec. 11.	{ NEW YORK HOSPITAL, Dr. Smith, half-past 1 P.M. BELLVEUE HOSPITAL, Dr. Sayre, Is. Hos., half-past 1 P.M. ACADEMY OF MEDICINE, half-past 7 P.M. PATHOLOGICAL SOCIETY, half-past 7 P.M.
Thursday, Dec. 12.	{ NEW YORK HOSPITAL, Dr. Peters, half-past 1 P.M. BELLVEUE HOSPITAL, Dr. Barker, half-past 1 P.M. OPHTHALMIC HOSPITAL, 1 P.M.
Friday, Dec. 13.	{ NEW YORK HOSPITAL, Dr. Watson, half-past 1 P.M. BELLVEUE HOSPITAL, Dr. Flint, half-past 1 P.M. EYE INFIRMARY, Dr. Noyes, half-past 1 P.M.
Saturday, Dec. 14.	{ NEW YORK HOSPITAL, Dr. Smith, half-past 1 P.M. BELLVEUE HOSPITAL, Dr. Parker, half-past 1 P.M. " " Dr. Wood's Clinic, half-past 2 P.M. OPHTHALMIC HOSPITAL, 1 P.M.

To Physicians.—Timolat's Old Established SULPHUR AND VAPOUR BATHS. Introduced in 1820 by L. J. TIMOLAT, from Paris, at No. 1 Carroll Place, Bleeker street, corner of Laurens street, New York. Given daily by

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By CHAS. T. JACKSON, M.D., F.G.S.F.
12mo. Boston, 1861. 75 cents.

SPECIAL NOTICES.

Dec. 7, 1861.

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Manual of Human Histology. By

C. MOREL, Professor at the College of Strasbourg. Translated and adapted to the wants of the Medical Student by W. H. VAN BUREN, M.D., Professor of Anatomy, University Medical College. 1 vol. 8vo, with 28 plates. Price, \$3.

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Sent Free by Mail on Receipt of Price.

Goodfellow, S. J. Lectures on the

Diseases of the Kidney, generally known as "Bright's Disease," and Dropsy. 12mo. London, 1861. \$2.85.

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On Diphtheria. By Edward Head-

LAM GREENHOW. 1861. Pp. 160. Price, \$1.25.

Our readers will find a very large amount of information in the twelve chapters of which the volume is made up. Perhaps, in the present state of our knowledge on the subject of this obscurely understood disease, little more can be said beyond what may here be found written down.—*London Medical Times and Gazette.*

We have only been able here to refer to certain of the more prominent facts concerning diphtheria; but we believe we have said enough to recommend this well-written treatise to the attention of the profession.—*British Medical Journal.*

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Compendium of Human Histology.

—By C. Morel, Professor Agrégé à la Faculté de Médecine de Strasbourg. Illustrated by twenty-eight Plates. Translated and edited by W. H. Van Buren, Professor of General and Descriptive Anatomy in the University of New York: 1861. Pp. 207. Price, \$3.00.

It is the best compendious treatise we have seen. The plates are admirable, some of them illustrating most beautifully the views of Virchow upon the office of the cell in the formation of tissues, both normal and pathological.—*Boston Medical and Surgical Journal.*

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do Ferruginous of Nancy for Rusty Water.
do Lozenges of Citrate of Iron.
do do of Lactate of Iron.
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do Syrup of Citrate of Iron.
do Syrup of Iodide of Iron.
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